Life Course Patterns and Risky Health Behaviors in Incarcerated Women

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Abstract

Nena Rashed Harris: Life Course Patterns and Risky Health
Behaviors in Incarcerated Women
(Under the direction of Dr. Margarete Sandelowski)

Incarcerated women have historically been recognized as living troubled and chaotic lives. They have been identified as a high-risk population with similarities to women with HIV. Accordingly, examining the life course of incarcerated women might aid in the identification of the pathways to risk behaviors associated with HIV and other threats to physical and psychosocial well-being. Set in life course theory, this study was directed toward examining the life course patterns associated with risky health behaviors in a subset of 15 women who completed both the questionnaire and life history interview components of the *Life Histories of Women in Prison, 1986-1987* study. A person-centered analysis was used to examine the distinctive variations in individuals' lives and involved the identification of life events and risky health behaviors across the life span. The analytic goal was to understand the life course pattern of each woman and its association with the onset of involvement in risky health behaviors. All women described cumulative disadvantage beginning in childhood. Women who experienced serial/overlapping disadvantage tended to become involved in risky health behaviors during pre- or early adolescence. Those experiencing isolated disadvantage were more likely to delay involvement in risky health behaviors until later in adolescence or adulthood. The findings highlight the

need for early and trauma-informed interventions that take into account women's individual experiences with and responses to physical, emotional, and psychological trauma. Such interventions might help to minimize women's involvement in risky health behaviors and improve health outcomes for women with chaotic lives.

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DEDICATIONS

This dissertation is dedicated to all of the women who live chaotic lives. Your plight is not going unnoticed and it is my prayer that, with time, work like this will help to identify ways in which effectively to combat childhood trauma and abuse and foster resilience, empowerment, and health in the face of sometimes unspeakable acts.

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Chapter I. Introduction

Incarcerated women suffer physical, emotional, and psychological health-related problems at higher rates than the average female population (Braithwaite, Treadwell, & Arriola, 2008; Nijhawan, Salloway, Nunn, Poshkus, & Clarke, 2010). They represent a group of women who are at high risk for a variety of health problems and who are underserved in regards to healthcare services (Braithwaite et al., 2008; Magee, Hult, Turalba, & McMillan, 2005; Nijhawan et al., 2010; Plugge & Fitzpatrick, 2004).

Incarcerated women have historically been recognized as living troubled and chaotic lives (McDaniels-Wilson & Belknap, 2008; Staton, Leukefeld, & Webster, 2003; Taylor, Williams, & Eliason, 2002), which in turn have been linked to health risks (Harris et al., 2003). Their lives therefore offer insight into the association between chaotic lives and health risk. The reasons underlying this chaos have been the subject of studies in nursing, public health, social work, psychology, and other health-related fields (Kubiak, 2004; Messina & Grella, 2006; Poehlmann, 2005; Zust, 2009). Incarcerated women have been identified as a high-risk population with similarities to women with HIV as well as to women with various other health problems. Accordingly, examining the life course of incarcerated women might aid in the identification of the pathways to risk behaviors associated with HIV and other threats to physical and psychosocial well-being.

Incarcerated Women as Exemplars of Chaotic Lives

Incarcerated women have been described as lacking social support and resources (Staton-Tindall, Royse, & Leukefeld, 2007; Wright, Salisbury, & Van Voorhis, 2007), as being marginalized or invisible (Braithwaite et al., 2008; Taylor et al., 2002), as lacking power in personal relationships (Knudsen et al., 2008; Wright et al., 2007) and institutional settings (Braithwaite et al., 2008; Pollack, 2004), at high risk for a variety of health problems (Magee et al., 2005; Plugge & Fitzpatrick, 2004; Sterk, Theall, & Elifson, 2005; Nijihawan et al., 2010), and as experiencing stigma (Leeder & Wimmer, 2007; van Olphen, Eliason, Freudenberg, & Barnes, 2009). Indeed, researchers have chosen to conduct studies with women prisoners in an effort to understand women's exposure to health risks and adoption of risky behaviors, and to understand health problems in demographically similar groups of women. For example, Brewer and Baldwin (2000) stated that their selection of incarcerated women for their study of breast self-examination practices was based on the knowledge that this population was demographically similar to those women at highest risk for breast cancer morbidity and mortality.

Demographically, incarcerated women are overwhelmingly impoverished, lacking formal education or vocational training that leads to gainful employment (DeHart, 2008; James, 2004). In its most recent report, the U.S. Bureau of Justice reported that only 40% of incarcerated women in 2002 were employed in the month prior to incarceration (James, 2004). Descriptive statistics of numerous studies with samples of incarcerated women indicate low percentages of employed participants and those who are employed often earn very little (e.g. Brewer & Baldwin, 2000;

Estébanez et al., 2002; Knudsen et al., 2008; Messina & Grella, 2006; Mooney et al., 2008).

Incarcerated women are also disproportionately comprised of ethnic and racial minorities, particularly African-Americans (Braithwaite et al., 2008; Freudenberg, 2002; Knudsen et al., 2008). In 2002, African-American women comprised only approximately 12% of the U.S. population, yet they generally represented approximately 40% of incarcerated females in the US (Harrison & Beck, 2003). In 2006, African-American females were almost four times as likely and Hispanic women almost two times as likely as Caucasian females to be incarcerated (Sabol & Harrison, 2007). Researchers who have recruited women for studies related to incarceration have frequently reported that minority women, especially African-Americans, are disproportionately represented in their samples of incarcerated women (Kubiak, 2004; Messina & Grella, 2006; Mullings, Hartley, & Marquart, 2004; Valentine & Smith, 2001).

Histories of childhood and adult abuse are an unfortunate refrain in the lives of incarcerated women (Brewer-Smyth, 2004; DeHart, 2008; Messina & Grella, 2006; Mullings et al., 2004). These women commonly report recent abuse from male partners or acquaintances (Knudsen et al., 2008; Zust, 2009). Over half of women entering jails in 2002 reported a history of sexual or physical abuse (James, 2004). Researchers have found violent victimization in large proportions of incarcerated women or women with a history of incarceration (DeHart, 2008; Messina & Grella, 2006; Sterk et al., 2005). A history of abuse can cause a shift in life trajectory and result in a trajectory characterized by participation in criminal activity leading to

incarceration, including substance abuse, violent crimes, and sex trading (Brewer-Smyth, 2004; DeHart, 2008; Logan, Leeb, & Barker, 2009; Sterk et al., 2005). Poor self-esteem, low self-worth, and involvement in self-destructive behaviors are common consequences of childhood and adult abuse (DeHart, 2008; Vigil, Geary, & Byrd-Craven, 2005) and may also interfere with health-promoting behaviors (Gielen, McDonnell, Wu, O'Campo, & Faden, 2001; Miller, 1999). Women reporting childhood sexual abuse are more likely to report illegal drug use, inconsistent condom use, a higher number of lifetime partners, and a higher number of lifetime sexually transmitted diseases (Abrams, Etkind, Burke, & Cram, 2008; Hillis, Anda, Felitti, & Marchbanks, 2001). In comparing incarcerated women to non-incarcerated women, Messina and Grella (2006) reported significantly higher rates of various forms of abuse for incarcerated women.

Substance abuse is a major reason for the incarceration of women; women were more likely to be incarcerated for drug offenses in 2002 than their male counterparts (James, 2004). Approximately one-third of incarcerated women were arrested for drug-related offenses in 2001 (Harrison & Beck, 2003). Increased national attention to drug crimes, with mandatory minimum sentencing, is one of the main variables contributing to the increasing rates of the incarceration of women (Radosh, 2008). Incarcerated women are highly likely to abuse drugs and/or be in a relationship with a man who abuses drugs. Females who are addicted to drugs are likely to have been introduced to drugs by their boyfriends or husbands (Lurigio, Swartz, & Jones, 2000). In 2002, female inmates were more likely to be dependent on drugs or alcohol (52%) than male inmates (44%). Women were also significantly

more likely to be dependent on drugs (61%) than alcohol (39%); men were only slightly more dependent on drugs (54%) than alcohol (50%; Karberg & James, 2005).

The same substance abuse practices that place women at risk for incarceration place them at risk for other health problems. In studies involving women prisoners, substance abuse has been associated with a range of other health problems, including childhood abuse and trauma (Messina & Grella, 2006), post-traumatic stress disorder (Kubiak, 2004), adverse pregnancy outcomes (Eliason & Arndt, 2004), HIV-related risk behaviors (Estébanez et al., 2002; Pearson et al., 2008), and mental illness (Blitz, Wolff, Pan, & Pogorzelski, 2005; Kubiak, 2004).

Studies with samples of incarcerated women include consistently high percentages of substance abusers (Harris et al., 2003; Leenerts, 2003). Even in studies in which investigators did not specifically list drug use as an inclusion criterion, rates of reported drug use were up to 80% (Harris et al., 2003; Mullings et al., 2000). Approximately 70% of women in state prisons have used drugs at some point in their lives. Of these, at least 50% have used hard drugs such as crack/cocaine or heroin (Zaitzow, 1999).

Incarcerated women are frequently single parents of small children (Glaze & Maruschak, 2008). Significantly more female than male inmates report that they are the primary caretakers of their children (Glaze & Maruschak, 2008). In 2004, 62% of women in state prisons and 63% in federal prisons reported being the parents of minor children. On the other hand, 51% and 56% of men in state and federal

prisons, respectively, reported being parents. In contrast to the 36% of male inmates who reported living with their children in the month prior to arrest, over 50% of female inmates reported living alone with their children prior to arrest; 42% of mothers reporting being single parents, compared to 19% of fathers who were single parents (Glaze & Maruschak, 2008).

Given the combination of all of these factors, it is not surprising that depression is often identified in incarcerated women (Lovell, Gagliardi, & Peterson, 2002; Staton et al., 2003). Women with histories of incarceration suffer from higher rates of depression than women in the general population (Gunter, 2004). In their study on recidivism, Lovell et al. (2002) found that the women in their sample were three times as likely to have depression than the men. Factors that possibly contributed to depression for these women included being childhood and adult victims of sexual and physical abuse (Miller, 1999; Zust, 2009), being separated from children (Loper, Carlson, Leveitt, & Scheffel, 2009; Poehlmann, 2005), and chronic stressors related to poverty and single motherhood (Mellins et al., 2003). Low education levels, low income, and substance abuse—all issues pertaining to incarcerated women—have also been found to contribute to depression (Richardson et al., 2001). Being incarcerated can further exacerbate depression (Keaveny & Zauszniewski, 1999), making it a variable that can contribute to behaviors that lead to incarceration or one that is a consequence of incarceration. Women in prison are also frequently diagnosed with other mental illnesses such as bipolar disorder, schizophrenia, and anxiety disorders (Blitz et al., 2005). In a report on mental illnesses in jail and prison inmates in 2005, James and Glaze (2006) noted that

women had higher rates of mental illnesses than male inmates. Female inmates meeting the criteria for mental illness were more likely to report recent homelessness, substance abuse and dependence, and a history of sexual or physical abuse (James & Glaze, 2006).

Researchers' focus on incarcerated women is a reflection of the complex nature of their lives and the challenges that threaten their physical, psychological, and social health. The range of topics that have been studied in this population offers insight into the many life challenges that incarcerated women face and provide data that can inform effective health promotion interventions for women living similarly chaotic lives.

Chapter II. Theory and Methods

Life Course Theory

Life Course Theory provided the substantive framework for this study, that is, for examining lives in a historical, developmental, and social context (Elder, 1998). The theory is comprised of four central themes: (a) the impact of life transitions and events is influenced by their timing in a person's life, (b) the lives of individuals are shaped by a historical context, (c) individuals live interdependent lives, and (d) individuals make choices within social and historical opportunities and constraints (Elder, 1998; Hendry & Kloep, 2002).

Foundational to these four themes are the concepts of transitions, trajectories, and turning points. Transitions are embedded in trajectories as a life trajectory will consist of multiple transitions shaped by developmental, societal, and historical factors. Trajectories are influenced by maturational, normative, quasi-normative, or non-normative life events, which are shaped by societal and cultural expectations of age-appropriate developmental milestones (Hendry & Kloep, 2002). Turning points are life events or transitions that create sudden, pivotal changes in the direction of a life trajectory (Wheaton & Gotlib, 2006); they have the potential to have a positive or negative influence on the trajectory depending on the appraisal of the event. In regards to health behaviors and risk exposure, life course theory directs researchers to examine the pathways that shape an individual's exposure to factors that place them at risk for physical, emotional, and psychosocial dysfunction (Alwin

& Wray, 2005). Trajectories, transitions, and turning points together contribute to or decrease health risk.

According to Elder (1998), the timing of life events is a key factor in life trajectories as early or off-time events (e.g., teenage parenthood or birth of child before marriage) can have an impact on subsequent transitions. Furthermore, such transitions can begin the process of the accumulation of disadvantages (e.g., dropping out of high school or inability to attend college, low job attainment, poverty, and poor housing conditions). Cumulative disadvantage, the pile-up of multiple stressors over time, can place a strain on emotional, social, and material resources that might otherwise facilitate positive, healthy decision-making (Hatch, 2005). Cumulative advantage refers to the availability of resources (e.g., financial stability, strong parental relationships, attainment of education) across the life span offering protection against stressors and adversity. Disadvantages and advantages have the potential to change the course of a life trajectory based on their impact at key developmental transitions (Hatch, 2005).

Instances of advantage and disadvantage are rarely static across an individual's life span. Therefore, consideration is given to the cumulative effect of advantage or disadvantage in the life course literature. Hatch (2005) summarized three possible processes by which cumulative disadvantage operate in a person's life. First, cumulative disadvantage can refer to an isolated factor that has persistent and chronic effects on the life course (e.g., poverty, single parent household). Second, cumulative disadvantage can be thought of as a series of stressors that occur one after another, giving the individual little respite from one stressor before a

new one ensues. Third, stressors can overlap, with a new one occurring while a previous one persists.

Developmental Life Events

According to Hendry and Kloep (2002), life events can be categorized into a variety of developmental shifts across the life span. They identified four major types of developmental events: (a) maturational, (b) normative, (c) quasi-normative, and (d) non-normative. Maturational events are defined as those that are physiologic and driven by biological changes such as puberty, menarche, and menopause. These shifts are predictable as they are experienced by women at roughly the same age.

Normative events are those prescribed by cultural and social mores or law and are shared by all members of a group (e.g., starting school, age of legal responsibility, retirement). As with maturational events, normative events are expected and predictable. Although somewhat predictable and expected, quasi-normative events are common and are likely to occur during a certain age range, but the timing can be influenced by changes in the social environment. These types of events, such as leaving home, getting a first job, marriage, and parenthood, can be experienced at different times depending on various family, social, and cultural expectations.

Non-normative events are those that are not shared by everyone. The classification of an event as non-normative is based on the timing and nature of the event. As Hendry and Kloep (2002) described them, types of non-normative events include:

1. Off-time events that are typically normative, but occur earlier or later and are shared with individuals in another age group. Examples include teenage pregnancy, early death of parents, and late marriage.
2. Historical events that are unpredictable and occur to everyone due to historical events. Examples include economic crisis, war, and natural catastrophes.
3. Self-instigated events that do not occur automatically and have to be initiated. These events are not expected socially, but are planned by the individual and may be associated with stigma. Examples include divorce and planned childlessness.
4. Idiosyncratic events that happen to only a few individuals, are not predictable, and are not necessarily shared by others. Examples include physical disability and winning the lottery.
5. Non-events are maturational, normative, or quasi-normative events that are expected to occur, but do not. Examples include unwanted childlessness and unemployment.

Overview of Methods

Life Course Theory framed a secondary analysis of data obtained in the study, *Life Histories of Women in Prison, 1986-1987*, the purpose of which was to understand the life factors associated with criminal careers in newly incarcerated women. All data were collected by Dr. Mary Gilfus and archived in 1992 with the Henry A. Murray Research Center of the Radcliffe Institute for Advanced Study at Harvard University in Cambridge, MA. Permission to access these data for the

proposed study was granted by the Murray Research Center after submission of an online form (see Appendix A). Once approved, a hyperlink to the archived data was provided via email. All data were downloaded from this website. A copy of the correspondence stating approval to access the data is included in Appendix B. This study was approved by the Public Health/Nursing Institutional Review Board of the University of North Carolina at Chapel Hill; documentation of approval is located in Appendix C. The data for the study consisted of questionnaire data and life history interview data already in the public domain. In the parent study, numerical identifiers and pseudonyms were used in the place of actual participant names. Pseudonyms used in the parent study were changed to a different set of pseudonyms for this study.

Since the data for the proposed study were collected, the body of literature demonstrating that incarcerated women are at risk for various health problems has grown considerably. For example, incarcerated women and women with HIV have been shown to have strikingly similar lives (Lurigio et al., 2000). At the time of data collection, women were considered at low risk for contracting HIV. Since then, women have contracted the disease at disproportionate rates compared to men and research has highlighted the constellation of factors contributing to this trend (Estébanez et al., 2002; Harris et al., 2003; Knudsen et al., 2008; Miller, 1999). Given this trend, understanding the lives of women incarcerated in the 1980s has relevance even now in helping to shed light on the life course pathways that influence participation in health-related risk behaviors in women with complex life histories.

Ninety-six women were recruited from July 1986 to March 1987 from orientation meetings for newly sentenced inmates at a female correctional facility in a northeastern state. The women ranged in age from 17 to 48 years (mean=29). White women made up 66% of the sample, 19% were African-American, 10% were Hispanic, and 5% categorized themselves as "other." The majority of women had never been married (34%), while 15% were married at the time of the study, 29% were separated, divorced, or widowed, and 22% had common law or live-in partners. Only 2% were college graduates with 19% having had some college education. Seventy percent had dropped out of school at some point in their lives; 34% completed high school or earned a GED.

In-depth life history interviews were conducted with a subset of 15 women from the larger sample; six additional women from a drug treatment and parenting education program were asked to complete life histories for comparison to the newly incarcerated women. An interview guide was used to ensure that all topics were addressed with each woman. The majority of these women was never married, had dropped out of high school, were addicted to intravenous drugs, were physically and/or sexually abused as children, and reported being victims of violence as adults. The interview guide containing the questionnaire and life history interview components of the parent study is provided in Appendix D.

Glifus (1989) described the challenges of collecting data for the parent study in the prison environment. The institutional restrictions in the prison presented significant challenges to sampling and data collection. Gilfus hoped to obtain a sample that was representative of the prison population, but widespread recruitment

strategies such as flyers were not feasible given the potential for bias due to volunteers who had participated in her programs through a local agency, or that more women would volunteer than she could logistically handle. Wanting to avoid turning women away and creating conflict between inmates, she opted for recruiting from orientation sessions for new inmates.

Questionnaire data were collected in small groups via 10 pages of closed-ended questions eliciting demographic information and information about family relationships, substance abuse, criminal activities, childhood and adult abuse and violence, and adult health problems. The life history interviews were conducted one-on-one in a private location. Gilfus (1989) described the challenges in finding a location in the prison that was private and quiet as well as comfortable. Because of overcrowding, space was very limited and scheduling was a significant obstacle. She was able to secure a supply closet as her dedicated interview room, but it contained no windows; ventilation was poor, it neighbored another frequently-used supply closet, and it sat next to the busiest corridor of the prison. As a result of the noise level, some portions of the taped interviews were difficult for her to hear.

In her research, Gilfus (1987, 1989, 1992) focused on women's paths from victimization to crime in her research reports. Findings emphasized the forces that drove women's participation in criminal activities, with a focus on experiences of childhood abuse and trauma and subsequent challenges accomplishing various developmental tasks. Brady's (2006) dissertation research, a secondary analysis of the original data, was a linguistic analysis of the incarcerated women's narratives with a focus on trauma and self-descriptions. Her findings revealed discernible

linguistic patterns in the correlations between narratives of trauma in childhood and descriptions of self in adulthood. The citations for publications from these data are listed in Appendix E; abstracts for the dissertations completed by Gilfus (1989) and Brady (2006) are included as well.

Research Purpose and Questions

The purpose of this study was to examine the life course patterns (Singer, Ryff, Carr, & Magee, 1998) associated with risky health behaviors in the subset of women ($n=15$) who completed both the questionnaire and interview components of the *Life Histories of Women in Prison, 1986-1987* study. Risky health behaviors were defined as behaviors that expose an individual to acute or chronic disease, disability, or death (e.g., smoking, intravenous drug use) or lack of participation in activities that are known to prevent disease, disability, or death (e.g., lack of condom use, lack of physical activity; Centers for Disease Control and Prevention, 2008).

The research questions for the study were as follows:

1. What maturational, normative, quasi-normative, and non-normative life events comprised these women's lives and how did women respond to these events?
2. In what risky behaviors had they engaged?
3. Are there distinguishable combinations of events, their timing, and women's responses to these events that were associated with their risky health behaviors?

The analysis approach used in this study was an adaptation of the person-centered strategies Singer et al. (1998), Maltz and Mullany (2000), and Sèguin et al.

(2007) described. Person-centered strategies are useful in the study of life course pathways as they take into consideration the timing and sequencing of developmental events and transitions in an individual's life over time (Maltz & Mullany, 2000). The following principles guided the Singer et al. person-centered strategy of life history analysis and served as the guiding analytic framework for this study: (a) the accumulation of disadvantage over time has negative effects on health, (b) the accumulation of advantage over time has positive effects on health, and (c) reactions to advantage or disadvantage mediate the impact of life events.

A person-centered analysis is focused on the distinctive variations in individuals' lives and involves the depiction of life events mapped across the life span. A key step in person-centered analyses is the creation of life timelines (Maltz & Mullany, 2000); Sèguin et al. (2007) referred to this as the life history calendar. Life timelines allow for the chronological sequencing of life events and visual comparison of variations in life pathways between individuals and the developmental and historical timing of life events (Maltz & Mullany, 2000). The timing of events has specific importance with regards to life events as years of sexual abuse beginning at the age of five, for example, will likely have a different impact from abuse occurring one time at age 16.

Working Hypotheses

The hypotheses for the study were roughly based on the research of Sèguin et al. (2007), who identified two primary life trajectories characteristic of those in their study who had committed suicide. First, suicide was a reaction to an accumulation of disadvantage beginning early in life. Second, suicide was a reaction to a key factor

that occurred later in life; these individuals had fewer challenges observed over the life span. Following these same principles and incorporating Hatch's (2005) categories of disadvantage, the hypotheses for the study were:

1. An earlier onset of risky health behaviors will be primarily associated with a life course pattern that can be characterized as *Serial/Overlapping Childhood Disadvantage*.
2. A later onset of risky health behaviors will be primarily associated with a life course pattern that can be characterized as *Isolated Childhood Disadvantage*.
3. For women whose life course patterns contain a childhood turning point, the onset of risky health behaviors will occur in pre-adolescence or early adolescence. For women with an adolescent or adulthood turning point, the timing of risky health behaviors will correspond closely to the timing of the turning point.

Sample

The 15 women who completed both the questionnaire and life history interview components of the parent study constituted the sample for this study. They are profiled in Table 1; as shown there, they ranged in age from 20 to 41 years old at the time of data collection. Nine women were Caucasian, three were African-American, and one reported mixed race; the remaining two selected "other" as their race/ethnicity. Ten of the women were mothers at the time of the interview. Nine women were never married, with four of these reporting being in common law relationships; an additional three women were married and three were separated. Seven women completed high school with two of these having post-high school

education. The remaining eight women did not complete high school. The majority of the women were incarcerated for drug-related offenses (n=7) or prostitution (n=4). Other offenses included larceny, possession of stolen property, driving under the influence, assault and battery, and breaking and entering.

Data Collection

The dataset that was used for the study included questionnaire data that provided information about discrete events, as well as interview data that provided information about both discrete events and women's reflective appraisals of those events.

Questionnaire data. A key step in data collection for the parent study involved selecting variables for the questionnaire that represent information important for understanding the life of each woman (Singer et al., 1998). These variables provide information about what has occurred over the life course and that, when taken together, capture the maturational, normative, quasi-normative, and non-normative events that have characterized each woman's life. Selected variables consist of life events identified in developmental literature as commonly shared across individuals (e.g., birth of siblings, school attendance, employment patterns) and non-normative events that have been identified as having the potential adversely to affect physical, emotional, and psychological health (e.g., physical abuse, numerous living situations, dropping out of high school, teenage pregnancy, unemployment). A summary of variables selected from the parent study for this study are listed in Table 2.

Interview data. Interview transcripts from the parent study were used in their entirety for the study. Details about variables not provided by the questionnaire data were captured in the interview data. Interviews lasted from three to five hours; transcripts range in length from 63 to 105 typed pages. These interviews were focused specifically on exposure to family violence, childhood sexual abuse, and other traumatic experiences. Detailed information about illegal activity (e.g., substance abuse, prostitution, stealing, and arrest history), family relationships, sexual development, childbearing, self-image, and work history was also elicited.

Data Analysis

In assessing the appropriateness of the original data for secondary analysis, the questionnaire data for each woman was used to create a data matrix using Microsoft Excel®. As a result of this work and perusing the interview transcripts, the data were deemed sufficient to address the research questions for the proposed study.

Organizing the data to allow for analysis consisted of the creation of a life history profile for each woman. Each life profile was comprised of: (a) a narrative summary of the woman's life (Singer et al., 1998), (b) a life timeline depicting the timing of key life events (Maltz & Mullany, 2000; Singer et al., 1998), and (c) an evaluative summary of the woman's reactions to various life events as they related to her involvement in health risk behaviors (Singer et al., 1998).

Using information in the data matrix, an initial life timeline was created for each woman using the questionnaire data. Information that was chronological in nature was organized as such, allowing for the visualization of a developing timeline

of key life events for each woman. The life history interviews provided additional, detailed information about life events, transitions, and turning points; this information was used to fill in the timing of life events that were not captured by the questionnaires. The combination of questionnaire and interview data was used to create a comprehensive life timeline that depicted the number, nature, and timing of key events in each woman's life. The age from birth ascending to the time of the interview was graphed on a horizontal line, and major life events were placed along the timeline with arrows to indicate the age of occurrence. Maturational or normative, quasi-normative, or non-normative events were placed on the life timeline; differentiation between maturational, normative, quasi-normative and non-normative events was necessary for analysis because the different types of events are presumed to play different roles in their relationship to health risk behaviors (Hendry & Kloep, 2002). Events were considered quasi-normative if their assignment as maturational, normative or non-normative was ambiguous or could depend upon the timing of the event or the woman's appraisal of the event (e.g., first sexual intercourse; Hendry & Kloep, 2002).

Life events were initially categorized by color to assist in visualization of similar life events between women. For instance, all events associated with puberty, sexual relationships, and reproduction were colored pink. After initial life timelines were completed and life course patterns were assigned, the life timelines were revised to highlight only those key life events and risky health behaviors that signified the life course pattern assignment for each woman. In the final versions of the timelines, life events were placed above the horizontal age line while risky health

behaviors were placed below. The final life timelines for each woman are displayed in Figures 1-15.

In addition to confirmation of questionnaire data and details about missing questionnaire data, life history interviews provided information about each woman's evaluation of her life events as well as the meaning assigned to them as they related to her participation in health risk behaviors. The life history interviews were organized and coded using NVivo 8® (QSR International, 2008). Passages from women's interviews were extracted and included in the life profile that reflected: (a) reasons why they participated in risky health behaviors, (b) explanations about the role that specific life events played in their decision to participate in health risk behaviors, and (c) discussions about any life events that they attributed to their participation in health risk behaviors. When a woman's questionnaire and interview data were thoroughly reviewed, a narrative summary of her life was created. The narrative summary was used to introduce the woman and provide an overview of her life with a focus on key life events and participation in risky health behaviors.

During the descriptive phase of data analysis, the life history profiles served as the starting point for understanding women's individual life course patterns as well as for making initial comparisons across women. Women's lives were analyzed on a case-by-case basis, which allowed for assignment of each woman to one of two cumulative disadvantage groups. Similarities and differences in life events, the timing of events, and the appraisal of events were considered for each woman. Based on Hatch's (2005) categorization of cumulative disadvantage, *serial/overlapping disadvantage* was defined as either a series of stressors or

overlapping stressors occurring throughout a woman's life; the nature of the interviews for this study did not allow for clear distinctions between the two types of stressors. *Isolated disadvantage* was defined as a woman describing one overriding factor that influenced her life course.

The analysis proceeded to an intra-group analysis, which consisted of making comparisons between the two groups of women assigned to the two categories of cumulative disadvantage. The lives of women assigned to the *serial/overlapping cumulative disadvantage* life course pattern were assessed for similarities and differences in life events, the timing of events, and appraisals of events. The same comparisons were then made for women assigned to the *isolated cumulative disadvantage* life course pattern. Next, an inter-group analysis allowed for comparison of women across groups. This served to verify placement of women in each group or refinement of groups based on the concepts of cumulative disadvantage.

After determining the nature of cumulative disadvantage for each woman (serial/overlapping vs. isolated), risky health behavior categories were assigned based on the timing of active participation in health risk behaviors (e.g., first drug use, first prostitution, multiple sexual partners, suicide attempts). These categories included: pre-adolescence (≤ 12 years old), adolescence (13-18 years old), and adulthood (≥ 19 years old). Life course patterns also included, where applicable, key turning points experienced by the women. These risky health behavior categories allowed drawing initial conclusions about the relationship between the type of disadvantage—as reflected by the nature of life events—and the onset of risky

health behaviors. Women's appraisals of life events as they related to their participation in risky health behaviors helped to determine the definitions and final assignments of life course patterns. Considering the combinations of cumulative disadvantage categories and risky health behavior categories, six potential life course patterns were theoretically possible:

1. Serial/overlapping cumulative disadvantage → Pre-adolescent onset of risky health behaviors
2. Serial/overlapping cumulative disadvantage → Adolescent onset of risky health behaviors
3. Serial/overlapping cumulative disadvantage → Adulthood onset of risky health behaviors
4. Isolated cumulative disadvantage → Pre-adolescent onset of risky health behaviors
5. Isolated cumulative disadvantage → Adolescent onset of risky health behaviors
6. Isolated cumulative disadvantage → Adulthood onset of risky health behaviors

As data analysis proceeded and new insights were gleaned from the data (from intra-woman, intra-group, and inter-group comparisons of life history profiles), the analytic goal was to understand the life course pattern of each woman and the process of becoming involved in risky health behaviors. The analysis was based on a temporal understanding of life events that was used to define trajectories in regards to the unstable, complex nature of incarcerated women's lives and the

timing of the onset of risky health behaviors. Throughout the data analysis process, the questionnaire and interview data were reviewed multiple times thoroughly to familiarize myself with the context of the lives of the women in the sample. Back-and-forth movement between the data and emerging interpretations aided in verifying placement of women in groups and intra-rater consistency, which, in turn, optimized the descriptive, interpretive, and theoretical validity of findings (Maxwell, 1992).

Chapter III. The Course of Women's Lives

Women's life trajectories were determined, in part, by the nature of key life events. Each woman's life was characterized by varying degrees of chaos and disruption; the variations can be seen in the type, timing, and duration of various life events, as well as her reactions to these life events. Each woman described one or more life events that either undergirded her entire life course, making it the theme of her life story, or drastically changed the path of her life trajectory from one that looked significantly different from before their occurrence.

Life Events

Maturational events are biologically-based and occurred during an expected age-range; these included puberty-related experiences and pregnancies. Normative events included those that are expected and shared by all women; early school attendance was the only normative event of significance that was common across all of the women in this sample. Some of the women's experiences of these supposedly expected and predictable life events varied in their onset or duration, making them potentially non-normative. Further, the circumstances surrounding their occurrence sometimes contributed to women's perceptions of normative events as quasi- or even non-normative. Women's responses to life events were a reflection of their perceptions of the events. Examples of women experiencing maturational or

normative events as non-normative included early menarche and pregnancy during adolescence.

Due to the parent study's aim of highlighting the chaotic nature of incarcerated women's lives, the discussion of non-normative events in the women's life history interviews far outweighed their discussions of normative events. All of the women reported disadvantage beginning in early childhood. Non-normative events that were commonly noted across women and, thus, determined their life trajectory assignments included: poor parenting practices, poverty, parental death, parental substance abuse, parental mental illness, exposure to violence, and physical, sexual, and emotional abuse and trauma, disruptions in school attendance, and negative puberty-related experiences.

School Attendance

The majority of women had a fairly typical early educational course. All of the women reported beginning school on time and doing well in their early school years. The middle and high school years, however, varied across women. The majority of the women in the sample ($n=11$) dropped out of high school; seven of these women returned to complete their diplomas or eventually obtained their GEDs. For most of the women, dropping out of high school was preceded by skipping school, disruptive behavior, or difficulty with keeping up their schoolwork. Women observed that they skipped school because their friends were doing it as well. Skipping school was also often a time when the women began using drugs or alcohol due to the unsupervised time that it afforded. Regardless of the reasons, behavioral and academic problems with school often served as an early sign of trouble.

Puberty-Related Experiences

Puberty-related experiences that women discussed included menarche ($n=15$), pregnancy ($n=10$), and perceptions of early physical development ($n=2$). Puberty was largely a maturational event that was expected and managed with whatever knowledge they had during that transition. A reliance on peers as the source of information about puberty and sexuality was a common theme across women. Women stated that their mothers were often reluctant or unwilling to communicate with them about their changing bodies. They told stories of their mothers' negative reactions to them asking questions about puberty-related topics or starting their periods. Two women had to rely on their sisters for information about puberty because their mothers had died by the time they reached that period in their lives.

Ages of menarche ranged from 8 to 16 years old, occurring between 11 and 13 years old for eight of the women who reported this information. For the majority of the women, menarche was an experience that was significant in that it was a time that symbolized a lack of communication and guidance from their mothers. One woman described having her first period when she was 8 years old; menarche was an off-time event that frustrated her because she perceived that her days of being a carefree child were over. Two women described early physical maturation and the feeling that their adult appearances often led to unwanted sexual attention from older men.

Ten women described pregnancies; five of these women were 15 years old when they experienced their first pregnancy. Pregnancy during adolescence, as

commonly conceptualized in developmental theory, was an off-time non-normative event that often preceded women's decisions to drop out of school or to remain in unhealthy or even abusive relationships with men. Even in instances where the pregnancy ended in an abortion, miscarriage, or adoption, the pregnancy negatively affected some women's already tenuous relationships with their parents; one woman expressed resentment that her mother forced her to have an abortion and then forced her out of the house. Another woman shared feelings of sadness over her parents forcing her to place her child for adoption.

Poor Parenting Practices

Descriptions of poor parenting practices were universal across all women. Taking on many different forms, they included physical absence, emotional distance, inconsistent and/or harsh discipline, lack of acceptance and affection, and a lack of supervision and protection. Poor parenting practices that consisted of drug and alcohol abuse and physical, sexual, or emotional abuse occurred also and will be addressed later in this chapter.

The majority of women expressed dissatisfaction with their parents especially their mothers. Even when women were physically or sexually abused by men in their lives, it was the mothers who took the brunt of the resentment. Women described mothers who were overly harsh or critical, or who did not protect them from sexual or physical abuse. Two women's mothers died during their childhood and adolescent years from physical illness. These women described troubled relationships with their fathers that were primarily characterized by emotional distance and lack of affection and supervision, which these women perceived as lack of concern for their well-

being. One woman's mother had repeated suicide attempts over the course of her childhood. Suffering from depression, her mother was emotionally unavailable to her for a significant portion of her formative years. As a teenager, her mother's last suicide attempt was successful and she was then left to live on her own.

Poverty

Four women reported having comfortable childhoods and classified their households as middle class; one additional woman reported that her family was very well off financially. The majority of the women ($n = 10$), however, reported being low middle class, working poor, or long-term welfare recipients.

Troubled Relationships with Men

Women described involvement in relationships that placed them at risk for harm. These included abusive relationships which led to physical injury or relationships with men who abused IV drugs, which potentially placed them at risk for acquiring HIV and other sexually transmitted infections through heterosexual intercourse. The majority of women ($n=9$) described physical abuse at the hands of the men they loved. Because most of the women had already begun using drugs before entering into any intimate long-term relationships, they described their troubled relationships with men as a factor in the escalation as opposed to the initiation of their drug use. Further, involvement in relationships with men was often a contributing factor to the women's arrest and incarceration histories.

Parental Alcohol and Drug Abuse

Six women described witnessing alcohol or drug abuse in one or both parents. With the exception of one woman, both of whose parents regularly used a

variety of drugs, these women's parents were addicted to alcohol. Three women described both parents abusing alcohol. The women who described alcohol use in their mothers frequently described having to take over their mother's responsibilities such as tending to the house, watching over any siblings, and having to clean up or take care of their mothers when they were drunk. Alcoholic fathers typically displayed aggressive or even abusive behaviors; much of the physical and sexual abuse described by women occurred in the context of alcohol and drug use.

Physical and Sexual Trauma

Four women reported childhood physical abuse; in all cases, the perpetrator was a male family member and included fathers, a stepfather, and an older brother. In each case, the women also reported that their mothers were aware of the abuse but did little to prevent it from happening.

Five women reported childhood sexual abuse. They experienced sexual abuse in varying degrees of severity in regards to perpetrator, age of onset, duration, and force. The sexual abuse experienced by the women included: an instance of fondling by a father; several rape attempts by multiple non-related persons; various sexual acts over four years by an uncle that did not involve penetration; rape by a foster brother; long-term sexual abuse and manipulation by a step-father; and violent sexual abuse by a father with graphic threats of bodily harm if the abuse was disclosed. As a result of their sexual abuse, some women described being fearful of interactions with men; others revealed that their sexuality was the only way that they knew how to relate to and interact with men.

Exposure to Violence

Four women described childhood exposure to violence. The most common form of violence consisted of intimate partner violence between their mothers and fathers or stepfathers ($n=3$). One woman described witnessing her uncle being beaten to death during a racially-motivated attack.

Two of these women further reported non-normative family relocations that were efforts to escape dangerous situations. One woman's family moved multiple times as her mother tried to escape her father's physical abuse. The woman who witnessed her uncle's murder also described her family having to move during a time of racial unrest in the South after the assassination of President Kennedy.

Risky Health Behaviors

The most common risky health behaviors in which these women engaged consisted of drug and alcohol abuse, sex work/prostitution, early initiation of sexual intercourse, suicide attempts, and multiple sexual partners. Defined as non-normative, self-instigated events by Hendry and Kloep (2002), these consisted of behaviors in which the women made a decision to engage. Such behaviors placed the women at risk for a variety of health-threatening conditions, including addiction and its associated conditions, sexually transmitted diseases, violence, and death. Most of the women in the sample began participating in risky health behaviors by the age of 15 ($n=11$), while two began in late adolescence and the remaining two in adulthood. Table 3 shows the health behaviors reported by the women in this study. Table 4 depicts risky health behaviors in which women engaged across the life span by age of participation.

Alcohol and/or Drug Abuse

Thirteen women reported drug and/or alcohol use at some point in their lives, with eleven of them reporting being addicted at the time of their interviews. One woman described herself as being addicted to both alcohol and drugs. Two others reported only an addiction to alcohol, although one of these women had used drugs during her teenage years. One revealed occasional marijuana use and another reported being a former addict with no current drug use. The two remaining women reported never abusing drugs or alcohol in their lives. The types of drugs used ranged from mild street drugs like marijuana, to prescription drugs such as Percocet, to hardcore street drugs like cocaine, heroin, and crack.

Most of the women's introduction to drugs was in their pre- or early adolescent years. For most of the women, their first drug use was associated with drug use by their peers. One woman was unique in that her drug use was introduced first by her babysitter and later by her parents, all figures of authority. Once they tried drugs, most of the women progressed to addiction, with episodes of cessation and escalation. Women usually stopped using drugs or alcohol as a result of being incarcerated or in rehabilitation. Some women reported decreased drug or alcohol use while pregnant. Escalation in drug use often coincided with relationships with men who also abused drugs; other times the women's drug use escalated as a reaction to a traumatic life event (e.g., a mother's death or trauma related to being incarcerated).

In contrast to alcohol abuse, the women who struggled with drug addiction were so consumed by the drugs that nothing else in their lives mattered. For most of these women, their drug use was just one in a series of poor decisions and a

downward spiral into chaos; the financial burden that drug addiction entailed, both in regards to money spent and loss of income through gainful employment, characterized these women's stories of their drug addiction. Although women who reported alcohol use seemed to exhibit more control over their life choices, both drug and alcohol addiction often became the backdrop against which other risky health behaviors occurred.

Sex Work/Prostitution¹

The majority of the women ($n=12$) had participated in prostitution at some point in their lives. For five women, it was the reason for their current or past arrests and incarcerations. Prostitution was mostly a means for obtaining money for drugs and/or living expenses for women, but was also used to support the habits of drug-addicted boyfriends or for companionship. Life on the streets for most of the women who participated in prostitution was harsh and dangerous. In addition to sexually transmitted infections, prostitution exposed the women to imminent physical harm and danger through violent sexual and physical assaults. For women who were using prostitution to support a drug habit, the violence that met them on the streets was often not enough to deter their drug addictions or using prostitution as a means to support their addictions.

Prostitution that was influenced by a strong addiction or fear of a drug-addicted boyfriend exposed women to numerous risks. Yet, one woman maintained some control over her prostitution; she described her deliberate decision to be

¹Although the term *prostitution* was used throughout the data from the original study, *sex work* is also used here to acknowledge the use of both *sex work* and *prostitution* in recent research literature. Hereafter, *prostitution* will primarily be used.

involved only with older men who were looking for companionship instead of sex. She perceived that this protected her from the aggressive and violent behavior of younger clients typical of other women's involvement in prostitution. She was also one of only two women who did not get involved in prostitution by force from a boyfriend or to support a drug habit. Consequently, she had the freedom to be very selective with her clients. In general, drug addiction—whether it was the woman's or her boyfriend's—was the driving force behind most of the women's prostitution, which resulted in an even riskier form of prostitution that lacked selectivity and establishment of basic safety precautions.

Early Initiation of Sexual Intercourse

For the 10 women who reported their first sexual intercourse, their ages ranged from 15 to 18 years old. Seven of them reported early initiation of intercourse, defined as 16 years old or younger (Zimmer-Gembeck & Helfand, 2008). Notably, the five women who did not mention their first sexual experience during adolescence had suffered sexual abuse during early childhood. One woman described her first sexual experience while in the presence of several drunken men as an agreement to have sex with one man only because she was faced with the alternative choice of being raped by the rest of them. Another woman's first sexual experience was when she was raped by her boyfriend at age 17; she later had sex voluntarily with another boyfriend about a year later. The remaining women reported that their first sexual intercourse was voluntary. Only one woman, who was a virgin until she was 18 years old, described her first sexual experience while in a stable relationship with a long-term boyfriend.

Suicide Attempts

A suicide attempt was the most direct threat to health of all the other risky health behaviors described. Five women reported suicide attempts, which typically happened after an event that triggered sadness or hopelessness. Each of these women tried to commit suicide at least once by taking an overdose of pills. Three women also had parents who had committed suicide during their childhoods.

Multiple Sexual Partners

Two women specifically discussed their involvement in multiple sexual relationships. One woman, by her own admission, reportedly had sex with 200 people by the time she was 16 years old. The other described her first sexual experience as one that occurred with a man that she had just met. Afterwards, she had sex with men that she met from week-to-week.

Chapter IV. The Interplay of Life Events and Risky Health Behaviors

All of the women's lives were categorized as having cumulative disadvantage beginning in early childhood, as indicated by the types of life events that they reported. As noted in chapter 3, non-normative life events that highlighted these women's lives and contributed to childhood disadvantage included: poor parenting practices, poverty, negative puberty experiences, exposure to violence, physical, and sexual trauma, and parental alcohol and drug abuse. As discussed by Hatch (2005), the three types of cumulative disadvantage are serial, in which a traumatic life event occurs as one is ending; overlapping, in which traumatic life events begin while others are in progress; and isolated, in which a single factor characterizes the disadvantage.

Based on these distinctions, two categories were used to identify the nature of cumulative disadvantage for the women in this study. Women who were assigned to the *serial/overlapping childhood disadvantage* group experienced multiple forms of the aforementioned life events that seemed to contribute additively to their life trajectory. These two types were combined because the exact timing and duration of life events—in other words, whether they began as others ended or overlapped—could not be discerned from the data. Women assigned to the *isolated childhood disadvantage* group described a single factor as the primary determining factor in their life trajectory. Women from both groups ($n=5$) described certain life events as

turning points; these were specific life events that occurred within the assigned life course patterns and either influenced the onset of disadvantage or exacerbated pre-existing disadvantage. For four of these women, their risky health behaviors were more distant in relation to their turning points; their turning points occurred in early childhood when parental oversight was a major protective influence in their lives. Their ages combined with parental supervision at the time of the turning points acted as a buffer until they were older and had opportunities to spend more time away from home and with peers. For the remaining woman, the interval between her turning point in adolescence and her first risky health behavior was short at approximately one year.

Both serial/overlapping and isolated disadvantage are types of cumulative disadvantage that resulted in narrowed life choices for women that contributed to their participation in a variety of risky health behaviors. They were placed in risky health behavior categories based on the timing of their initial participation in a risky health behavior. Risky health behaviors in which the women were involved included: alcohol and drug abuse, suicide attempts, sex work/prostitution, early sexual intercourse, and multiple sexual relationships that were unrelated to sex work/prostitution. Early sexual intercourse was not considered as a deciding factor for placement in a risk health behavior category. Although early sexual intercourse plays a contributing role in the transmission of sexually transmitted infections and multiple sexual relationships (Donenberg & Pao, 2005), early intercourse was rarely the first risky health behavior in which these women engaged. The two women who did report early sexual intercourse as their first risky health behavior did not report

another risky health behavior for at least five years afterward, suggesting that the early intercourse did not establish an immediate pattern of risky behavior for those women (Siebenbruner, Zimmer-Gembeck, & Egeland, 2007).

Taking into consideration women's cumulative disadvantage group and their the onset of risky health behaviors (pre-adolescent, adolescent, and adult) women were assigned to five of six potential life course patterns:

1. Serial/overlapping disadvantage → pre-adolescent onset of risky health behaviors
2. Serial/overlapping disadvantage → adolescent onset of risky health behaviors
3. Isolated disadvantage → pre-adolescent onset of risky health behaviors
4. Isolated disadvantage → adolescent onset of risky health behaviors
5. Isolated disadvantage → adulthood onset of risky health behaviors

In general, the majority of the women who demonstrated involvement in risky health behaviors in pre-adolescence or by early adolescence experienced *serial/overlapping disadvantage*. Women with *isolated disadvantage* tended to begin their risky health behaviors later in adolescence or in adulthood. There were no women who fit the criteria for assignment to the *serial/overlapping disadvantage* → *adulthood onset of risky health behaviors*. Life timelines displaying a visual depiction of each woman's life course pattern are located in Figures 1-15.

Serial/Overlapping Disadvantage with Pre-Adolescent

Onset of Risky Health Behaviors

Four women experienced serial/overlapping disadvantage and began participating in healthy risk behaviors at the age of 11 or 12. Although each of them reported a variety of life events that warranted their group assignment as serial/overlapping disadvantage, three of the women experienced sexual ($n=2$) and physical ($n=1$) abuse, all perpetrated by male family members. In each case, the women reported that their mothers were aware of the abuse but did little to stop it; this challenged their feelings of trust and safety and made them feel like any attempts at disclosing their abuse were futile. The trauma of enduring abuse at the hands of a loved one in addition to a lack of protection by yet another loved one seemed to play a key role in the life choices that the women in this group made. For one woman, a turning point—one that exacerbated already existing disadvantage—preceded her abuse. Although the fourth woman with this life course pattern did not experience sexual or physical abuse, she suffered significant emotional neglect due to her mother's depression and multiple suicide attempts and eventual suicide-related death.

Their initial risky health behaviors consisted of smoking cigarettes, drinking alcohol, and using illicit drugs. All of the women assigned to this life course pattern also participated in prostitution, mostly to support a drug habit. One woman was introduced to prostitution at 13 years old by an older boyfriend. Each woman was also addicted to drugs at the time of her interview.

Carol's Life Course

Carol's serial and overlapping disadvantage consisted of poverty, her father's death when she was 5 years old, and her mother's mental illness and subsequent

suicide when Carol was 18 years old. For much of her childhood, Carol and her mother needed government assistance to make ends meet. Her mother suffered from mental illness and alcoholism; she was hit by a truck on three separate occasions beginning when Carol was 5 years old shortly after her father's death. Carol suspected that her mother was trying to commit suicide the first two times and that the third time—when Carol was 18 years old—she was finally successful. Her mother had been foreshadowing her death from the time she was 16 years old, saying, "When you're 18, I'm just gonna die. I have nothing to live for." Carol was an only child, so when her mother died, she was left to manage life on her own.

Carol was 12 years old when she started smoking cigarettes and drinking alcohol and was using drugs by 14 years old. When she was 15 years old, Carol was hanging out with a group of drunken men, who tried to force her to have sex; she managed to regain some control over the situation by negotiating to have sex with only one of them. Her drug use escalated when she began to shoot heroin after her mother's death. Carol noted that the drugs helped to dull the pain of the loneliness that she felt being in the house by herself.

By the time she was in her 20's, Carol was using prostitution to support her drug habit, which mainly consisted of alcohol and heroin. When she was 23 years old, Carol tried to commit suicide by overdosing on barbiturates. Shortly after her suicide attempt, she went into a rehabilitation program for the third time, but returned to shooting heroin soon after leaving. She remained clean for five years during the time that she had her four children, but after the birth of her last child, Carol went back to shooting heroin. By her late 20s, she was shooting 20-30 bags a day of

heroin. She tried to commit suicide again before her incarceration; when she came out of her coma, she managed to shoot heroin while in the hospital. Carol's life timeline depicting serial/overlapping disadvantage and pre-adolescent onset of risky health behaviors is displayed in Figure 1.

Iris' Life Course

In early childhood, Iris experienced an unstable home life. She witnessed years of fighting between her parents and their subsequent divorce. As a 7-year-old, she continued to witness domestic violence between her mother and stepfather. At the age of 9, Iris' mother attempted to commit suicide and by the time she was 13 years old, her mother and stepfather had also divorced. Iris also endured disadvantage in the form of her mother's and stepfather's drug use, her stepfather's sexual abuse, and exposure to sexually explicit behaviors in her home. Iris remembered that her mother and stepfather regularly used drugs from the time she was around 10 years old. She referred to them as "hippies" and noted that their drug use consisted of marijuana, LSD, acid, amphetamines and other psychedelics. Iris' stepfather started to become affectionate with her around age 10 or 11; by age 14 his attention turned sexual. Her mother had moved out of the house; she was in school at the time and did not have much time for her, so Iris stayed with her stepfather. Her stepfather started to treat her as if she was his wife by taking her to parties and dinners, and having drinks with her. She was not sure that she had ever slept with him "all the way" since she was often high on drugs or he would give her Demerol. He would throw large parties at the house; many of them were orgies. Iris summed up her relationship with her father by saying, "I didn't really have a clear

picture of what normal would have been.” Iris’ last time sleeping with her stepfather was in exchange for money to move to where her mother was living.

Iris’ babysitter introduced her to marijuana when she was 11 years old; it was not long before she was smoking it on a regular basis. She also started to use the LSD that her mother would bring home from her research job. By the time she was 16 years old, Iris had slept with approximately 200 people; she noted that sex was her way of getting close to men. Iris was often depressed during her teenage years and frequently considered suicide from the time she was 14 years old. Yet, she never actively planned a suicide attempt until less than a year prior to her interview. She took a handful of pills that were a mixture of whatever she had lying around. She spent 5 days in a psychiatric facility and then moved into her father’s half-way house for 6 months. Iris tried “real” prostitution for the first time in the year prior to her incarceration but stopped after being arrested and concluding that it was not worth the money. Iris’ life timeline depicting serial/overlapping disadvantage and pre-adolescent onset of risky health behaviors is displayed in Figure 2.

Jackie’s Life Course

Jackie reported not remembering much of her early childhood, however she observed that “when it was good, it was really good; when it was bad, it was really bad.” She described various traumatic life events that comprised the accumulation of disadvantage that characterized her life. As a child, Jackie’s mother suffered from various medical illnesses and spent a lot of time in the hospital; she also suffered from depression and threatened suicide on a regular basis. Between being sick, her

frequent bouts with depression, and talking about killing herself, Jackie never knew if her mother was going to live or die.

Jackie recounted sexual abuse from her uncle that started when she was 8 years old and lasted 4 years. The abuse, which Jackie never disclosed, consisted of him showing her nude pictures, touching, and masturbation; there was no penile penetration. When Jackie was around 12 years old, she learned that her father had committed suicide when she was an infant. Up to this point, Jackie believed that her father had died of a heart attack. In her early teens, Jackie spent 3 to 4 years in and out of foster care, group homes, and temporary shelters. While she was in one home, a foster mother's son raped her. At 15 years old, she became pregnant. Offering support, her mother asked her to come home when she was 5 months pregnant; she forced Jackie into having an abortion despite her protests. After she recovered at home, her mother kicked her out of the house.

Jackie started smoking marijuana when she was 12-13 years old. When she was 13-14 years old, Jackie ran away to New York with a man who introduced her to prostitution. Her drug use escalated to shooting heroin after the uncle who abused her died when she was 16 years old. She also became involved in a relationship with a man who physically abused her and forced her back into prostitution, during which time a client attempted to kill her. By her late teens, Jackie was heavily addicted to hard drugs. Her drug use involved sniffing and shooting cocaine as well as heavy drinking. She had had bouts of being clean for 5 or 6 months at a time, but otherwise was always high or drunk. Jackie also tried to commit suicide three times. She ingested pills when she was 14 and 17 years old due to feeling depressed. The

third time was in the year prior to her interview and she cut her wrists in the heat of an argument with her mother. She was taken to a psychiatric hospital and placed on anti-depressants, but she stated that she preferred the drugs and alcohol. Jackie's life timeline depicting serial/overlapping disadvantage and pre-adolescent onset of risky health behaviors is displayed in Figure 3.

Brenda's Life Course

Brenda's early childhood was marked by her parents' frequent absence in the home and times of uncertainty regarding her father's health. Her father was in and out of the hospital for months at a time for 15 years with tuberculosis. Her mother was either working or visiting her father in the hospital for much of Brenda's childhood, so the children were frequently cared for by an aunt or uncle for the first 5 years of her life. Brenda's oldest brother became a father figure as her father was away so much in the hospital. At age 7, this brother was deployed to Vietnam. His return home sparked a change in their relationship and was the turning point in Brenda's life that compounded the disadvantage that had already begun during her early childhood. Her brother, upon returning home from Vietnam, began physically abusing her. Both her mother and father knew that he was abusing her, but only her mother attempted to control it sometimes. Once, he beat her up so badly with his officer club that she had 15 scars on her skull. Another time, Brenda suspected that her brother had beaten her black and blue while she was passed out after coming home drunk. As a result of her brother's beatings, she reported that she experienced flashbacks that were triggered by blue (police) uniforms. Referring to a recent arrest, Brenda stated that she "lost it" when a police officer tried to hand-cuff her.

Brenda began using drugs when she was 12 years old. By the time Brenda was 13 years old, she was drinking heavily and coming home drunk. At age 14, she was using drugs such as speed, acid, THC, and heroin “all the time” and cocaine occasionally. When she was 17, Brenda began using prostitution to earn money for drugs; she did not remember her first time because she was high. Once, Brenda was kidnapped off the street by a man at knifepoint and was beaten and raped. Less than a year prior to her interview, Brenda’s drug use escalated after her mother’s sudden death; she said that she could not face the reality of her mother’s death. This time, she started shooting cocaine and “fell in love” with it so much so that she used it more than heroin. She nearly died when she overdosed on cocaine shortly before her incarceration. Brenda’s life timeline depicting serial/overlapping disadvantage, a childhood turning point, and pre-adolescent onset of risky health behaviors is displayed in Figure 4.

Serial/Overlapping Disadvantage with Adolescent

Onset of Risky Health Behaviors

Two women with serial/overlapping disadvantage began participating in risky health behaviors at the ages of 15 and 16 years old. Both of these women, among other life events they experienced, witnessed violence during their childhoods. For one woman, this violence consisted of her mother’s abuse from her father; the other woman witnessed her uncle beaten to death in a racially-motivated dispute as a child and also experienced physical abuse from her father. One woman’s risky health behavior consisted of drinking as well as driving while intoxicated; the other’s

consisted of drug use and prostitution. Both women remained addicted at the times of their interviews.

Kate's Life Course

Kate's cumulative disadvantage in early childhood was characterized primarily by violence in the home. Kate's parents were alcoholics. Her father used to beat her mother every weekend, which the children called "Friday night fights." They often moved around in an effort to get away from their father whenever he got drunk. Yet, he would always find them. Additionally, Kate's father had been molesting her sisters and tried to fondle her once when she was 5 years old. Kate believed that her mother already knew about him molesting her sisters, but did not confront him until after this incident with Kate. The father went to jail for a long time after which Kate never heard from him again. When Kate was around 7 or 8 years old, her younger sister was runover by a car and killed. After her sister's death, Kate and her siblings suffered neglect because her mother sank into a deep depression and began drinking again. Later that year, Kate experienced a disruption in her schooling when she was stricken with rheumatic fever and had to spend 2 years out of school.

In her adolescent years, Kate experienced the death of her boyfriend, who was killed while fighting in the Vietnam War. She also experienced several rape attempts. Twice, she was fondled while babysitting by the fathers of the family, one of whom was a police officer. Another time, a stranger assaulted her while she was walking down the street. A couple of rape attempts were by men that she was dating.

Kate was an alcoholic at the time of her interview. Other than one episode of intoxication when she was 15 years old, Kate only drank socially until she got married at 22. As a way of dealing with physical abuse from her husband, Kate returned to drinking heavily and frequently placed herself in danger. On several occasions she required protective custody; she had had three arrests for driving under the influence at the time of her interview. Kate's life timeline depicting serial/overlapping disadvantage and adolescent onset of risky health behaviors is displayed in Figure 5.

Evelyn's Life Course

Evelyn's early childhood was marked by her personal and societal experiences with racism and violence. Her family and home were often the targets of racial attacks; she also recalled neighbors being killed. She told of witnessing her uncle's murder during a racially motivated attack. She and her uncle were walking in a local neighborhood when two white men approached her uncle and accused him of walking on the lawn. They began to argue and the two men beat and kicked her uncle to death in front of her. Evelyn also remembered the assassination of President Kennedy and the subsequent riots as an event that sparked her family's relocation to another neighborhood.

Both of Evelyn's parents also struggled with alcoholism. Evelyn's father was in the Air Force; as a result, he was gone for long periods of time. Often, the children would have to cook and clean for themselves when their mother was drunk. Her father's retirement from the Air Force was the turning point in Evelyn's life that exacerbated an already disadvantaged childhood. He began drinking heavily when

he returned home and became physically abusive towards her mother and the children. In recounting the worse incident of abuse, Evelyn recalled that he hit her in the face with a bed slat; as a result, Evelyn ran away from home. She ran away from home repeatedly in the years that followed; each time, the police would bring her back home. When she was 15, she was sent to a boarding school for one year for running away from home. After a twin pregnancy ended in miscarriage, she became pregnant again soon after and had her first child by age 17.

As a teenager, Evelyn had to defend herself from the sexual advances of men. A friend of her father's, on multiple occasions, tried to rape her or her sister when he would visit when he knew the parent's would not be home. Evelyn's boss was also sexually aggressive and tried to corner her in back rooms of the store. She had to quit to avoid his sexual advances. Another incident involved a woman who was a friend of the family.

As Evelyn spent more time away from home, her life of trouble started. Her risky health behaviors began at 16 years old, when Evelyn began working as a prostitute, using cocaine, and shooting heroin. After some time in a drug rehabilitation program, she moved in with her boyfriend and quickly resumed her drug use. Initially her boyfriend did not want her prostituting. Yet, whenever he was going through withdrawal from drugs, he would ask her to go out and make some money; as a result, Evelyn was using prostitution to support both her own and her boyfriend's drug habits. Evelyn's life timeline depicting serial/overlapping disadvantage, a childhood turning point, and adolescent onset of risky health behaviors is displayed in Figure 6.

Isolated Disadvantage with Pre-adolescent Onset of Risky Health Behaviors

Two women identified one overriding factor that characterized their lives and influenced their participation in risky health behaviors in their pre-adolescent years. One woman endured sexual and physical abuse from her father. The other woman described violent fighting with her older siblings; these fights were a common occurrence that began after the death of her mother, the turning point in her life that disrupted the stability in her home. Initial risky health behaviors for both women consisted of drinking alcohol and smoking marijuana; both women then quickly progressed to use of harder drugs later in adolescence and the use of prostitution to support their drug habits.

Helen's Life Course

Her early childhood was marked by sexual and physical abuse by her father coupled with a lack of protection from her mother; this was the one factor that predominately influenced Helen's life trajectory. Her father severely beat Helen and her sister on an almost daily basis. He also molested them by performing oral sex and manual penetration. He never tried penetration with his penis although there was genital contact. Her mother knew about the abuse, but did not do anything because of his threats. Helen's father was a hunter; he would kill a deer and skin it in their backyard while the girls watched. He would tell the girls that he would skin them also if they disclosed the abuse. He regularly hung the girls by their ankles during his abuse, so when she witnessed him doing the same to the deer, Helen feared that he would make good on his threat. Helen finally told her kindergarten teacher about the abuse; both her parents beat her when they found out that she told. By the time

Helen turned 6 years old, her parents had separated and Helen, her mother, and her sister moved into an apartment. The image of her father hanging her by the ankles like those dead deer was one that still haunted Helen. Helen harbored a great deal of anger towards her mother for not protecting her from her father's abuse and punishing her when she reported the abuse as well as her continued harsh treatment of Helen after the separation from her father.

Helen began drinking when she was 11 years old and was using drugs by 13 years old. She started smoking marijuana on the weekends. By 15-16 years old, she was shooting drugs and drinking on a regular basis; she considered herself to be an alcoholic at the time of her interview, but said that was not the case until she became an adult. Helen's life timeline depicting isolated disadvantage and pre-adolescent onset of risky health behaviors is displayed in Figure 7.

Anne's Life Course

Anne described her mother's death from metastatic breast cancer when she was 7 years old; this was the turning point that preceded a life of isolated disadvantage for Anne. She described a chaotic home life that consisted of constant discord and fighting. Before her mother's death, Anne remembered her family doing fun things such as outings on the weekends and family trips. After her mother's death, Anne recalled her father working all of the time and never being home; she described him as emotionally distant. All of a sudden, her father was "left with daughters that he didn't know what to do with." She remembered she and her siblings having violent fights on a regular basis, sometimes resulting in injuries. She also took on much of the household responsibilities and care of the younger

children. Later, an older sister returned home to help, something that Anne perceived her sister resented. Anne had little supervision or accountability at home, however, she and her father fought constantly as she approached adolescence.

Wanting to avoid as much tension as possible, Anne spent less and less time at home. At around 12 years old, she began running away from home, smoking marijuana, and drinking. By the time she was 15 years old, she was shooting heroin. At 18 years old, she began using prostitution to support her drug habit, which cost her more than \$2000 per week. Anne described her clients in the early years of her prostitution as well-groomed and of a high caliber. In the years leading up to this incarceration, however, she had become less selective and her clients had become abusive; she had been raped 10 times by her clients. Anne's life timeline depicting a childhood turning point, isolated disadvantage, and pre-adolescent onset of risky health behaviors is displayed in Figure 8.

Isolated Disadvantage with Adolescent Onset of Risky Health Behaviors

Five women were characterized as having isolated disadvantage and participated in their first risky health behavior as adolescents. For three of these women, their isolated disadvantage consisted of emotional trauma from their parents. Another woman witnessed domestic violence between her parents while the remaining one suffered physical abuse from her stepfather. The woman who experienced physical abuse described her mother's marriage to her stepfather as the turning point that preceded the onset of her isolated disadvantage.

The majority of the women in this group ($n=4$) reported drug use or drinking as their first risky health behavior. The remaining woman had a suicide attempt as her first risky health behavior.

Francine's Life Course

Francine described not having very many memories of her early childhood. Her early memories of fighting between her parents primarily comprised her isolated childhood disadvantage. She remembered that her aunts and uncles would come and have her and her brother spend the night with them when her parents started getting drunk and fighting. When she was 10 years old, she came to the realization that her parents were alcoholic and that this was the reason behind much of their violent behavior towards one another and poor parenting practices.

Francine started using drugs when she was 15 and was using them regularly by the age of 16. Francine would steal money from her mother in order to buy marijuana for herself and her friends. Francine's first sexual experience was at age 16 with a man that she had met the same day; she did not use any protection or birth control, but did not worry about getting pregnant. She then went on to become involved in many sexual relationships with men with whom she did not have relationships. She had sexual intercourse with approximately one man a week. Around this time, Francine started to get involved with prostitution; she had suffered three violent attacks from customers while prostituting. Her drug use escalated to free-basing cocaine when she was around 18 years old. She had been in jail for 21 days at the time of her interview and this was the longest time that she had gone

without using drugs. Francine's life timeline depicting isolated disadvantage and adolescent onset of risky health behaviors is displayed in Figure 9.

Nancy's Life Course

Nancy did not discuss many details of her childhood. She remembered her mother's constant criticism as the one factor that primarily influenced her life trajectory. She began to develop anger towards her mother as a young girl because she always compared Nancy to other children, including her siblings. Her mother would ask her, "Why can't you be more like them?" This made Nancy feel as if she never took her side or listened to her and as though she was an embarrassment to her mother. She recalled having horses and ponies as a child and that she identified with one horse in particular that had been beaten and abandoned. As she neared adolescence, Nancy became increasingly introverted and spent more and more time away from home because of how her mother treated her. She would be gone from home for days at a time.

When she was around age 14, Nancy started stealing albums and delivering drugs for a man in the neighborhood; it was during this time that she also started using drugs. Her drug use gradually increased and she also found herself in an abusive relationship. Eventually, Nancy married another man; he was addicted to drugs also and Nancy's drug use escalated. In the year prior to her interview, their drug habit had grown to shooting 40-60 bags of heroin a day. Nancy was serving her first sentence; the morning of her arrest, she had used 22 bags of heroin. Nancy's life timeline depicting isolated disadvantage and adolescent onset of risky health behaviors is displayed in Figure 10.

Gayle's Life Course

Gayle described her grandmother's death when she was 8 years old as the turning point that preceded her life of disadvantage. Until then, she and her brother lived with her grandparents; Gayle remembered that time was filled with happy memories. When her grandmother died, Gayle's mother picked her and her brother up to live with her stepfather. Her stepfather was physically abusive; she recalled the beatings happened at least a few times every week. At one point, when she was around 12 years old, he tried to "feel her up," but did not go beyond that. Soon after, he started accusing her of having sex, although she did not have sex until she was 17 years old. Her stepfather's abusive treatment is the primary factor that Gayle described as the disadvantage in her life. Her uncles would come and get her and take her to New York for months at a time to get them away from her stepfather. Her mother would eventually take her back home. During these stays in New York, Gayle missed out on key socialization time with her peers because she would not attend school.

Gayle began drinking when she was 15 years old. When she was 18 years old, she began prostitution while in a relationship with a boyfriend. Her boyfriend gradually took on the role of her pimp and was physically abusive. By the time she was 20, Gayle began using drugs and quickly became addicted. To deal with the trauma of having been in jail, Gayle began shooting heroin when she was 23 and escalated to free-basing when she was 32 years old. Her drug use increased in frequency in the years that led up to her incarceration. Gayle's life timeline depicting

a childhood turning point, isolated disadvantage and adolescent onset of risky health behaviors is displayed in Figure 11.

Ophelia's Life Course

Ophelia noted that her father's lack of acceptance of her was the one thing that shaped her perception about her life. She repeatedly stated in her interview that she did not have a normal childhood. The child of a Korean mother and African American father stationed in Korea, she called herself a "war baby" and lived in an orphanage in Korea until she was three years old, at which time her parents adopted her. Ophelia's adoptive parents were very protective of her but her father was also very mean. He wanted a son and whenever Ophelia misbehaved, he would threaten to send her back to Korea. Her father's threats to return her and his expressions of disapproval are what marked Ophelia's memories of her childhood.

Ophelia started using acid in high school when she was 17 years old. At 19 years old, she was also smoking marijuana and drinking. When she was 20 years old, she got involved with prostitution after a boyfriend gave her a choice between making money on the streets or going back home to live with her parents. Having experienced freedom from her adoptive parents, Ophelia chose to prostitute to make money rather than return home. At 30 years old, while in a relationship with a man who was addicted to cocaine, Ophelia began using cocaine as well. Not long after starting to use cocaine, she also started shooting heroin. When her father died, he left her \$30-40,000 in settlement money; Ophelia spent all of the money in five months due to her drug habit. Ophelia's life timeline depicting isolated disadvantage and adolescent onset of risky health behaviors is displayed in Figure 12.

Diane's Life Course

Growing up, Diane recalled that she and her siblings often craved more attention from their father. Diane's father traveled often, but when he was at home, he was just "there"; her mother took care of the children, made all the rules, and tried to encourage her father to be more available emotionally for his children. Diane identified her father's emotional distance as the single factor that shaped her memories of her childhood. Maids, chauffeurs, and butlers were a common part of Diane's childhood. Born into a wealthy family, her mother kept the family together financially and emotionally; she "wore the pants." When she was 14 years old, her mother got sick with cancer and she died when Diane was 16 years old; Diane identified her mother's death as a turning point in her life. After her mother's death, Diane's father became even more distant emotionally. The family was very close when her mother was alive, but after her death "everyone went their own ways;" they only came together for holidays at the time of her interview and the communication between everyone was poor.

Diane took her mother's death the hardest; she blamed herself, saying that she resented her mother needing her help. Diane became depressed for over a year after her mom's death. At 17, she tried to commit suicide by taking her mother's cancer pills and was hospitalized for two weeks. Diane began smoking marijuana when she was 18 years old. She used it only occasionally, mostly on the weekends. Her first time prostituting was performing oral sex to get money for tickets to a concert when she was 24 years old. When she was 27 years old, she began working with a call girl service. Her clients were "high class" and were mostly older men in

their 50's and 60's. She usually did not engage in intercourse with the men and admits that she often looked to them as father figures; most times, they just wanted company and to spend money on her. When she did have sex, it was always oral and she always used a condom. Diane's life timeline depicting isolated disadvantage and adolescent onset of risky health behaviors is displayed in Figure 13.

Isolated Disadvantage with Adulthood Onset of Risky Health Behaviors

Two women were assigned to the final life course pattern reflecting isolated disadvantage with risky health behaviors that began in adulthood. Neither of these women experienced any physical or sexual trauma or any other violent trauma, but endured poor parenting practices that consisted largely of emotional trauma.

Prostitution and a suicide attempt were the only risky health behaviors reported by these women. Compared to the rest of the women in the sample, they engaged in the least amount of risky health behaviors. Neither of them had ever been addicted to drugs or alcohol; one woman had tried them once with her siblings, but otherwise stayed away from drugs and alcohol.

Linda's Life Course

Linda's life trajectory was comprised of *isolated childhood disadvantage* in the form of poor parenting practices. Her parents divorced when Linda was 4 years old; her father was absent from that time forward. Her mother remarried and Linda recalled that there was constant verbal fighting between the stepfather and her mother.

When she was 20 years old, Linda was introduced to prostituting by her friend and did it to help pay bills. She and her boyfriend were being threatened with

eviction from their home if she did not come up with money in three days. She only performed oral sex and always used a condom. She did it every once in a while just to catch up on bills. When they were behind financially, she would prostitute to acquire money. She cried for several days the first time it happened, but she became used to it with time. After a year of prostituting, she was arrested for the first time. Linda's life timeline depicting isolated disadvantage and adulthood onset of risky health behaviors is displayed in Figure 14.

Mandy's Life Course

Her mother's emotional abuse was the factor that most influenced Mandy's life trajectory. Her mother always compared her to her older sister and made Mandy feel like she was not wanted. She was verbally and emotionally abusive and would tell Mandy, "I'm not your mother. Your mother died in the war." She drowned Mandy's kittens in a bucket of water in her presence. When she was 10 years old, Mandy decided no longer to allow her mother to hurt her. Mandy never again cried over anything her mother said or did to her, however, the tenuous relationship between Mandy and her mother continued well into Mandy's adult life.

Mandy's adult years were characterized by a series of unsuccessful marriages; two of her husbands were abusive. She experimented with drugs when she was 30 years old, but never struggled with addiction. When she was 37 years old, Mandy tried to commit suicide in an attempt to escape from all of the chaos in her life, including coping with several failed marriages, her current husband's addiction, the troubled interactions between her mother and sister, and her father's

death. Mandy's life timeline depicting isolated disadvantage and adulthood onset of risky health behaviors is displayed in Figure 15.

Chapter V. Discussion

In this study, I examined life course patterns of disadvantage and associated risky health behaviors in a sample of incarcerated women. All of the women in this sample experienced some degree of disadvantage that began in childhood. Women were assigned to five out of six life course patterns based on the combinations and nature of key life events and the age of onset of risky health behaviors. *Serial/overlapping childhood disadvantage* represented the accumulation and repetitive nature of traumatic childhood events in the lives of six of the women; together, these life events shaped the course of their lives with no single event standing out as the key contributing factor. *Isolated childhood disadvantage* was identified in nine women as a life course pattern that was comprised of one prevailing factor that, from each woman's perspective, played a dominant role in determining the shape of her life course. In addition, five women across both groups of cumulative disadvantage identified turning points, which were key life events that preceded the onset of disadvantage or exacerbated serial/overlapping or isolated disadvantage that had already ensued. After the nature of the women's disadvantage was determined, women were assigned to one of three risky health behavior categories based on the pre-adolescence, adolescence, and adulthood timing of onset of participation in risky health behaviors. Six women began participating in risky health behaviors in pre-

adolescence, while seven reported risky health behaviors beginning in adolescence. Two women engaged in their first risky health behavior as adults.

The findings of the study supported the hypothesis that those women with serial/overlapping disadvantage would be more likely to participate in risky health behaviors at earlier ages than women whose life course patterns consisted of isolated disadvantage. Four out of six women with serial/overlapping disadvantage had pre-adolescent onset of risky health behaviors compared to two out of nine women with isolated disadvantage. Isolated childhood disadvantage characterized the lives of women who began participating in risky health behaviors in late adolescence or adulthood. When women identified turning points in childhood, participation in risky health behaviors ensued during early adolescence when parental supervision decreased and time spent with peers increased. One woman who identified a turning point that occurred in adolescence demonstrated risky health behaviors with an onset in close proximity to the timing of her turning point.

Women who began participating in risky health behaviors at a young age tended to report more risky health behaviors across the life span. This trend is also supported by research findings indicating that earlier initiation of risky health behaviors results in increased risk behaviors in subsequent years of life (Donenberg & Pao, 2005; Stueve & O'Donnell, 2005; Zimmer-Gembeck & Helfand, 2008). Women who delay engagement in risky health behaviors typically demonstrate fewer risky behaviors across the life span due to more conservative attitudes toward various risk behaviors (Zimmer-Gembeck & Helfand, 2008) and having relatively less time for exposure to health risk.

No women were assigned to the life course pattern of *serial/overlapping disadvantage and adulthood onset of risky health behaviors*. The finding that women whose lives were characterized by serial/overlapping disadvantage all participated in risky health behaviors before adulthood was expected. Compared to isolated disadvantage, serial/overlapping disadvantage reflects a type of disadvantage that seemed more unrelenting and unending—and sometimes more directly traumatizing—than the life events that comprised isolated disadvantage, resulting in poor self-perceptions that facilitated early engagement in risky health behaviors.

One factor all of the women described was poor parenting practices that had a long-reaching effect on the women's life course patterns and was manifested in various forms. Consistent with prior research findings, poor parenting practices the women described were often the result of alcohol and drug use in parents (Lam, Fals-Stewart, & Kelley, 2009; Wells, 2009). During adolescence, poor parenting practices are further manifested as lack of supervision and control as children's time with parents decreases and is replaced by time with peers. Lack of family closeness and parental monitoring is associated with early sexual initiation, drug use, and involvement in criminal activity (Anderson, 2008; Roche, Ahmed, & Blum, 2008). Furthermore, women's stories were characterized by the desire for information about physical development and puberty that was not offered or was avoided by their mothers even when confronted with questions. Mothers are a primary source of information about puberty and sexuality for adolescents (Cooper & Koch, 2007; Guilamo-Ramos, Jaccard, Dittus, & Collins, 2008); when mothers do not maintain open communication about these experiences with their daughters, there may be

perceptions of emotional distance and close-mindedness as evident in these women's descriptions of their experiences.

Poverty created the backdrop against which many life events reported by these women arose and were then fostered. Poverty creates a context in which access to resources are limited. Poverty plays a role in the neighborhoods in which a family lives, the food that a family eats, and the education family members receive. Poverty can also determine the hope that individuals have in the face of hardship (Bolland et al., 2007); poverty increases vulnerability to the often unexpected challenges of life and can contribute to feelings of lack control over life (Dashiff, DiMicco, Myers, & Sheppard, 2009). Children growing up in low-income or impoverished neighborhoods may be chronically exposed to high rates of crime, violence, and drug use (Dashiff et al., 2009). Poverty may also significantly influence involvement in risky health behaviors either through a sense of hopelessness (Bolland, 2003; Bolland et al., 2007) or as a result of developing a sense of normalcy about various risky health behaviors (Dashiff et al., 2009). Poverty may also affect the manner in which parents treat their children. Children in impoverished families are likely to take on adult pressures and responsibilities (Burton, 2007). Furthermore, distress, fear, and tension caused by poverty may lead to parenting styles that are overly harsh or overprotective; this, in turn, can create a hostile home environment that adolescents avoid by spending more and more time away from home.

Childhood physical and sexual trauma played a significant role in determining the life course and participation in risky health behaviors for women in this study who

reported those experiences. This was especially true when the abuse occurred in the presence of a “non-protecting bystander” (Miller, 1996). This person was usually the mother; the combination of an abusive father, stepfather, or other father-figure and the non-protecting bystander mother reflects an extreme of poor parenting practices that contributed to women’s poor sense of self-worth and, therefore, their participation in self-destructive, risky health behaviors.

Childhood exposure to violence, as reflected in four women’s life narratives, has been associated with poor mental health and behavioral outcomes including post-traumatic stress disorder, depression, and substance abuse (Banyard, Williams, Saunders, & Fitzgerald, 2008). In regards to intimate partner violence, young girls who witness the violence between their parents have been found to exhibit more risky sexual behaviors in adolescence (Elliott, Avery, Fishman, & Hoshiko, 2002). A family’s residential mobility can be an indicator of adverse events such as the presence of violence (Dong et al., 2005). When women discussed family relocations, it was typically perceived as a normative event that occurred due to the types of jobs that their fathers had or due to poverty and needing to find a home that would be easier on the budget. Turner et al.’s (2006) research addressing the mental health of children and adolescents suggests that non-victimization events such as witnessing violence or experiencing the threat of danger are forms of adversity that, when taken together with other life events, can contribute to cumulative childhood disadvantage. The presence of danger can harm a child’s sense of security and can transform a seemingly normative event into a non-normative one characterized by disorder and instability.

Although individuals might identify stressful or even traumatic moments in their childhoods, it is their response to these life events that in part might determine their engagement in risky health behaviors. The women in this study all displayed some form of maladaptive coping, which led to their involvement in a variety of risky health behaviors. Responses that were not directly life-threatening, but created the opportunity to engage in such behaviors included skipping or dropping out of school, running away from home, and associating with peers who engaged in physically or criminally risky behaviors. When adolescents skip school or run away from home, they remove themselves from adult supervision, which allows for delinquent behavior to go unchecked. Reflective of research examining the effects of truancy in adolescents, such responses open the door for experimentation with drugs and sexual activity (Bond et al., 2007; Henry, Thornberry, & Huizinga, 2009; Roche et al., 2008), which, for these women, often progressed to drug addiction and sex work/prostitution and/or multiple sexual partners. Therefore, that drug and alcohol use and sex work/prostitution were the most frequently reported risky health behaviors was an expected finding. Furthermore, because of the original study's focus on women's criminal activity and the overlap with health risk, these behaviors, in particular, stood out among the others as the most common risky health behaviors for these women.

Researchers exploring the lives of incarcerated women overwhelmingly depict their participation in drug activity and sex work/prostitution—often to support drug habits, as demonstrated by the women in this study—as the typical picture of these women's lives. Drug addiction and prostitution typically went hand-in-hand for these

women and exposed them to numerous other health risks. As drug habits became more and more expensive, prostitution became the most convenient way for these women to obtain drugs or money for drugs. In many ways, the same self-perceptions that drove a woman to engage in drug use and prostitution were the same self-perceptions that led to other risky health behaviors.

Multiple sexual relationships and suicide attempts, although not reported as frequently in this study as other risky health behaviors, are also reflections of poor self-worth and efforts to escape any memories of trauma, lack of protection or concern, and instability that women may have experienced in childhood. Multiple sexual relationships can be a manifestation of early and unhealthy sexualization—through unwanted sexual attention and/or abuse—or a woman's attempts to find acceptance and unconditional love (Hillis et al., 2001); exposure to further emotional harm as well as unplanned pregnancy and sexually transmitted infections are the unfortunate consequences of multiple sexual relationships.

Suicide attempts have been associated with adverse childhood events (Clements-Nolle, Wolden, & Bargmann-Losche, 2009; Fergusson, Woodward, & Horwood, 2000) and subsequent depression, anxiety, and post-traumatic stress disorder (Coughe, Resnick, & Kilpatrick, 2009; Dube et al., 2001). Although symptoms of depression, anxiety, and post-traumatic stress were not measured in the original study, women often revealed feelings of sadness, hopelessness, and anxiety in their narratives. Although all of the women experienced various childhood events that reflected lives of cumulative disadvantage, that three of the five women who had attempted suicide had a parent who had done so suggests the significant

impact that a parent's suicidal behavior might have on the tendency also to attempt suicide (Cerel & Roberts, 2005; Melham et al., 2007), possibly due to a genetic predisposition to mood disorders that increase suicidal behavior (Brent & Mann, 2006; Cerel & Roberts, 2005) and maladaptive responses to or exacerbated familial dysfunction as a result of a parent's suicidal behavior (Kuramoto, Brent, & Wilcox, 2009).

The narratives of the women in this sample were characterized mostly by non-normative and often traumatic life events and various risky health behaviors, which parallel findings in other studies indicating the chaotic nature of women's lives with a history of incarceration. Perhaps the most compelling description of life pathways is from Daly's (1992) work in which she identified five pathways by which women enter felony court. These pathways, although focused on criminal activity, are noteworthy for examining the life events and health behaviors of women in this study. Daly used *harmed-and-harming women* to describe those who were neglected or abused as children, exhibited behavior problems as a child, were typically drug-addicted, and were unable to demonstrate adaptive coping mechanisms in stressful life situations. The *battered women* were those women involved or recently involved in an abusive relationship. *Street women* either ran away from abusive home environments or were forced out onto the streets; likely also to be drug-addicted, they used prostitution, theft, and selling drugs to support their drug habits. Women who were addicted to drugs due to a relationship with a boyfriend were called *drug-connected women*. Women who were involved in criminal activity due to economic hardship or greed were placed in the *other* category.

Although Daly placed the women in her study in these mutually exclusive categories using these labels, each woman in this study displayed various combinations of characteristics in some or all of these categories.

The findings of this study offer a general understanding of the context of these women's lives including how various life events shaped women's perceptions of themselves and the role that those perceptions played in their involvement in risky health behaviors. Feelings of despair, insecurity, and hopelessness were prevalent in these women's life stories. Coping with ongoing, indefinitely stressful or traumatic life events sends a message that life is unsafe and unpredictable. One conclusion that can be drawn from the women's lives is that childhood trauma, in varying degrees of severity, makes women vulnerable to risky health behaviors largely due to deficits in self-worth, agency, and self-efficacy. These women, through their life experiences, learned that any efforts at self-preservation were often futile, thus the lack of perception of risk or the desire to "get away from it all" was reflected in their drug addiction and other behaviors that exposed them to harm.

Clinical Implications

The findings of this study suggest that comprehensive and early intervention before adolescence is needed for young girls who have experienced serial/overlapping or isolated childhood disadvantage, as reflected in their experiences of childhood trauma and adversity. The potential that these young women will engage in risky health behaviors in adolescence and adulthood necessitates careful assessment of the immediate and long-term psychological impact that traumatic childhood events have on individuals. Healthcare providers as

well as those in various social services fields are in a unique position to intervene when they become privy to information about traumatic events that have occurred in childhood, regardless of the timing of the disclosure. Knowledge that a traumatic experience in childhood could result in risky health behaviors should prompt clinicians to suspect and inquire about such events in individuals who exhibit self-destructive health behaviors such as substance abuse, multiple sexual partners, sex work/prostitution, and suicide attempts.

Screening for Trauma and its Sequelae

In the clinical setting, it is unrealistic to expect a clinician to have a battery of instruments available for women presenting with histories of trauma. The clinician must decide, based on the nature of the intervention to be carried out, which instrument or combination of instruments most appropriately reflects the resources desired by the woman (e.g., a woman presently in an abusive relationship and in immediate danger versus one with a history of childhood trauma trying to learn how to identify healthy relationships). The variation in instruments and the need for specialized psychological intervention may make the use of varied abuse assessment tools an inefficient use of time for the clinician not trained in abuse and trauma care. Familiarity with selected tools used in trauma research and assessment for improvements in outcomes, however, can offer clinicians some insight into the nuances of trauma histories that are important to note, including the nature of such trauma and the psychological impact of the trauma on the woman because the impact of the trauma will play a key role in determining a woman's health-related behaviors in adulthood.

Selected tools available to assess for traumatic childhood events. The Adolescent Family Inventory of Life Events and Changes (A-FILE; McCubbin, Needle, & Wilson, 1985) is a 50-item self-report instrument that measures normative and non-normative life events that have occurred in the adolescent's family during the preceding year. Subscales include: (a) transitions, (b) sexuality, (c) losses, (d) responsibilities and strains, (e) substance use, and (f) legal conflict.

The Childhood Trauma Questionnaire (Bernstein et al., 1994) contains 70 items and can be used to assess women's childhood experiences of abuse and neglect as well as experiences related to child-rearing. Items are rated on a 5-point Likert scale and represent experiences of sexual, physical, and emotional abuse and neglect and family dysfunction. Each item begins with "When I was growing up" and responses range from "never true" to "very often true."

The Early Trauma Inventory (Bremner, Vermetten, & Mazure, 2000) is comprised of 56 items that assess traumatic life experiences occurring prior to age 18 across four domains: (a) physical abuse (9 items), (b) emotional abuse (8 items), (c) sexual abuse (15 items), and (d) general trauma (24 items). Each domain is introduced by an open-ended question that allows respondents to share their experiences in their own words with follow-up by a series of probes. Probe questions range from those that reflect less severe experiences to more severe traumas in each domain. The Early Trauma Inventory assesses occurrence and frequency of trauma experiences at different developmental or academic periods, duration, and perpetrators of abuse, as well as the current impact of the trauma. A post-interview

debriefing period is also included as part of the process for administering the inventory.

The Childhood Trauma Interview (Bernstein et al., 1994) contains a 7-point scale for respondents to rate the frequency and severity of traumatic experiences during childhood including physical, emotional, and sexual abuse, physical neglect, separation, and witnessing domestic violence. Opening questions and follow-up probes are used to gather data on the nature, frequency, duration, and severity of childhood trauma.

The Questionnaire on Childhood Sexual Abuse (Hulme & Agrawal, 2004) lists 13 sexual activities in order of pervasiveness (ranging from noncontact abuse such as exhibitionism or masturbation to full contact penetration) and asks respondents to state whether any of these were experienced before the age of 18. If a woman responds with a yes, information regarding the onset, frequency and duration of the abuse, as well as the relationship to the abuser(s) and any methods of coercion used, is obtained.

The Trauma Symptom Checklist-40 (TSC-40; Briere, 1996 as cited in Sikkema et al., 2004) is a 40-item self-report instrument assessing common symptoms associated with experiencing traumatic events as a child and/or adult. Respondents are asked to rate the frequency with which they experience listed symptoms in the preceding two months on a 4-point Likert scale ranging from 0 (*never*) to 3 (*often*). The TSC-40 contains six subscales: anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbance (Sikkema et al., 2004).

The Trauma Symptom Inventory (Briere, 1992 as cited in Kessler & Bieschke, 1999) measures various forms of posttraumatic distress across 10 areas on a 4-point scale ranging from 0 (*never*) to 3 (*often*). The scales assess for the presence of symptomatology related to trauma experiences and include: (a) anxious arousal, (b) depression, (c) anger and irritability, (d) intrusive experiences, (e) defensive avoidance, (f) dissociation, (g) sexual concerns, (h) dysfunctional sexual behavior, (i) impaired self-reference, and (j) tension reduction behavior.

Interventions for Women with Histories of Trauma

Regardless of the type of formal or informal tool chosen to assess for trauma and its impact, clinicians must be committed to making themselves aware of the community resources available for women with histories of trauma so that prompt action can be taken, including referral of the woman to someone trained in caring for women with such histories. There is a lack of trauma-informed interventions targeted at women who engage in risky health behaviors. Women with a history of trauma comprise an underserved group of women needing a gender-sensitive, trauma-informed intervention that will address HIV-related risk behaviors (Manfrin-Ledet & Porche, 2003). Given the current research establishing strong correlations between risky health behaviors and trauma, an intervention with a goal of minimizing responses to traumatic experiences (i.e., PTSD or depression) can be expected also to minimize behaviors that threaten women's health. For example, women with symptoms of PTSD and/or severe depression are more likely to engage in high risk sexual behaviors (Miner et al., 2006); these women are also more likely to abuse substances (Miller, 1999). Through effective interventions, a woman who uses drugs

to numb the memories of sexual abuse may decrease her risk for HIV by reducing participation in sex trading for drugs or money to buy drugs. Sex trading driven by addiction results in impaired decision-making regarding poor choice of partners (i.e. those who also use drugs) and lack of condom use. Furthermore, being high or intoxicated while engaging in intercourse also impairs decision-making.

Based on the understanding of the factors that play a role in risky health behaviors in women (i.e., adverse childhood events such as abuse), trauma-informed interventions acknowledge the potential for adversity in women's lives and reflect an attempt to deal with risky health behaviors as a mechanism for coping with that adversity. When women are able to reframe their experiences in a way that allows them safely to process their emotions, their coping skills are enhanced (Fallot & Harris, 2002; Najavits, Weiss, Shaw, & Muenz, 1998). Interventions designed to decrease psychological symptoms and increase cognitive skills empower women and help them to gain control over their emotional responses to traumatic memories. Trauma-informed methods of rehabilitation for substance abuse have gained popularity as an effective method for treating substance abuse in women. This model can be extended to include more risky health behaviors exhibited by women with histories of abuse. A brief description of three trauma-informed therapies currently being used is provided below.

Seeking Safety. An integrated group intervention, *Seeking Safety* addresses both trauma and substance abuse in women. This intervention was rated as helpful by the participants who demonstrated positive effects on PTSD symptoms, substance abuse, and rates of recidivism (Zlotnick, Najavits, Rohsenow, & Johnson,

2003). The *Seeking Safety* treatment consists of 25 topics that address cognitive, behavioral, interpersonal, and case management needs of women having problems with substance abuse and PTSD (Najavits, n.d.). By emphasizing stabilization, increasing coping skills, and reducing self-destructive behaviors, the treatment acknowledges many of the deficits that characterize this population and might interfere with recovery (Zlotnick et al., 2003).

The session topics included in the *Seeking Safety* treatment are as follows: (a) introduction/case management, (b) safety, (c) PTSD: taking back your power, (d) when substances control you, (e) honesty, (f) asking for help, (g) setting boundaries in relationships, (h) getting others to support your recovery, (i) healthy relationships, (j) community resources, (k) compassion, (l) healing from anger, (m) creating meaning, (n) discovery, (o) integrating the split self, (p) recovery thinking, (q) taking good care of yourself, (r) commitment, (s) respecting your time, (t) coping with triggers, (u) self-nurturing, (v) red and green flags, (w) detaching from emotional pain (grounding), (x) life choices, and (y) termination (Najavits, n.d.).

Trauma Recovery and Empowerment Model (TREM). TREM was developed as a group intervention for women with severe mental illness focused on addressing the long-term emotional, cognitive, and interpersonal sequelae that women with histories of physical and/or sexual abuse endure (Fallot & Harris, 2002). Like *Seeking Safety*, TREM emphasizes skill-building and symptom reduction by facilitating enhancement of personal strengths and mastery of life coping skills for women with histories of trauma. Within this model, women—many of whom may also have a substance use disorder—are able to acknowledge the role of abuse in

their lives but focus on recovery. TREM is based on four core assumptions that provide the foundation for treatment. First, TREM acknowledges that any present maladaptive behaviors or symptoms may have stemmed from a woman's initial coping strategy for dealing with trauma. A second assumption is that women experiencing trauma have missed out on opportunities for developing effective coping skills as adults. Third, intimate connections to family, community, and self-awareness are destroyed as a result of trauma. Lastly, women who have suffered chronic trauma lack empowerment and the ability to advocate on their own behalf. TREM consists of 33 topics that reflect these four assumptions; women meet weekly in small groups of 8-10 over a 9-month period. The 33 topics are focused on 11 areas of skill attainment: (a) self-awareness, (b) self-protection, (c) self-soothing, (d) emotional modulation, (e) relational mutuality, (f) accurate labeling of self and others, (g) sense of agency and initiative-taking, (h) consistent problem-solving, (i) reliable parenting, (j) possessing a sense of purpose and meaning, and (k) judgment and decision making (Fallot & Harris, 2002).

Addiction and Trauma Recovery Integration Model (ATRIUM). ATRIUM was founded on the belief that women will re-enact their trauma experiences via participating in self-destructive behaviors and addresses the challenges of treating addiction in individuals with histories of childhood trauma (Miller, 2002). ATRIUM was designed with the understanding that overcoming addiction is especially difficult in those whose addiction is a coping mechanism for dealing with experiences of psychological trauma. According to Miller (2002, p. 161), ATRIUM operates on four key principles, which include: "(a) recognizing and reinforcing resiliency, (b)

achieving abstinence from addiction, (c) recognizing and healing the wounds of nonprotection, and (d) creating a reverence for life couple with a sense of social purpose.”

Trauma-informed interventions such as Seeking Safety, TREM, and ATRIUM are not yet a part of the mainstream of psychological services offered to women with histories of childhood and/or adult abuse. Women’s healthcare providers should make themselves aware of any therapists in their communities offering these types of programs. For providers serving a large population of at-risk women, careful consideration should be given to having a staff member trained in any of these counseling techniques. Women who are at high risk for poor health outcomes due to their participation in risky health behaviors need to be assessed for histories of childhood trauma and offered the best community resources that are available. Even general informal assessments (e.g., “Before the age of 18 were you ever forced to perform sexual acts against your will?”) can be adapted to reflect more specific behaviors, emotions, and symptoms associated with trauma and can be used as a way of identifying those who may benefit from more intensive forms of intervention. As more and more research is conducted on the effectiveness of trauma-informed interventions for substance abuse and other risky health behaviors, the number of counseling centers offering trauma-informed programs is likely to increase. This could be a vital next step in strengthening health promotion and prevention efforts for high-risk women.

Research Implications

Ongoing research concerning the impact of trauma in women's lives is necessary in order for clinicians to know how best to assist women with histories of traumatic childhood events. Accurate and comprehensive assessment of traumatic events as well as women's responses to these events will enable researchers to draw clear conclusions about effective prevention and intervention. How trauma is assessed is influenced by how it is conceptualized and defined. A consistent and comprehensive conceptualization of trauma in research has been an ongoing challenge, resulting in limitations in the operationalization of the concept. The measurement of trauma varies across disciplines and from one study to the next. Some researchers define trauma in a broad category that encompasses all types and definitions of trauma as perceived by the recipient without specifying the specific type of trauma suffered by the woman. Broad conceptualizations make it difficult to establish correlations between various outcomes of trauma and the specific types and nature of such trauma (Smith, Thornton, DeVellis, Earp, & Coker, 2002).

Other researchers have focused their definition of trauma on one type, a conceptualization that does not acknowledge the evidence that many women experience more than one form of trauma in their lifetime (Arata, 2000; Coker, Smith, McKeown, & King, 2000). There is no perfect conceptualization of trauma and any operationalization of trauma will have its strengths and limitations. Researchers must decide, based on the nature of the study to be carried out, which instrument or combination of instruments most appropriately reflects the aims and objectives of the research. Yet, the implications of using specific or non-specific conceptualizations of trauma in research must always be considered and addressed. In the case of

specific conceptualizations of trauma, the researcher must be aware of the potential for recall bias. Women may have trouble accurately remembering the number of episodes in a given time period, in addition to the onset and duration of trauma (Smith, Smith, & Earp, 1999). This bias may be even more exaggerated for women with histories of substance abuse or severe mental illness whose memories may be impaired. For women with extensive histories of trauma, obtaining specific details about each type of trauma experienced and/or details about different perpetrators may lead to respondent burden, especially if the woman is also being asked questions about health status and risky behaviors. Likert-type scales that provide a continuum of options to report frequency relieve women of the pressure of having to specify an exact number of episodes (Smith et al., 1999), but may introduce some subjectivity because a woman's perception of frequency might be influenced by a variety of factors.

Future research that explores the meaning that women place on traumatic life events will further an understanding of the role that such events play in their health behaviors across the life span. The data used in this study were analyzed in such a way that the information was used as an index of what actually happened in the women's lives. There was no investigation into why the women may have focused on certain details of their lives and not others. An alternative approach could have employed narrative analysis, which is focused on the "how" and "why" of stories rather than the "what" of the women's stories that was the analytic strategy used in this study (Lempart, 1994; Riley & Hawe, 2005). Narrative analysis gives consideration to the notion that some details of the storyteller's life might be

exaggerated while other details are not featured at all (Ezzy, 2000). Ezzy (2000) described heroic and tragic narratives in his research on job loss. Heroic narratives were those in which the storyteller acted with autonomy, while the storytellers in tragic narratives were victims of forces outside of their control. Through tragic narratives, the storyteller is able to remove the burden of responsibility for their life choices and place it on external forces (Ezzy, 2000). The tragic narratives told by the women in this study may have afforded them compassion and protection from judgment as they gave voice to a story that they likely had not had the opportunity to share with a neutral person not associated with the criminal justice system or a drug treatment program. In some cases, their stories may have been exaggerated or formed in such a way that only the worst parts were highlighted to justify the series of life choices that had resulted in their incarcerations and risky health behaviors. Narrative inquiry that explores how women with chaotic lives tell about their lives will extend understanding beyond the association between life events and risky health behaviors and incorporate women's emotional and psychological framings of their experiences.

Limitations

The most important factor limiting the conclusions that can be drawn from this study is that associated with any secondary analysis effort (Szabo & Strang, 1997). My analysis was confined to data from a set of archived records. There was no way of returning to participants to clarify inconsistencies in information or to obtain more detail about events. Indeed, there were a few occasions when information about the same events conflicted between the questionnaire responses and life history

interviews. I could not determine whether this was related to participant recall or some other factor related to how information was elicited. Memory is especially challenging when eliciting information from individuals with histories of substance abuse, trauma, and mental illness, which might alter the participants' ability to recall the timing, nature, and duration of events (Smith et al., 1999). In cases of inconsistency, I made the decision to use the information from the narrative interview because it provided more information in context and, therefore, was likely to be a more valid response than a response to a single item on the questionnaire. These contradictions consisted mostly of descriptions of the timing of events, particularly arrests and incarcerations. In addition, not all topics were explored with all of the women; information about common experiences (e.g., puberty) was not available for comparison across all women.

Despite the limitation of using archived data, the information gleaned from this study offers insight into relationships that had not been explored at the time the data for the parent study was collected. Because of the overlap between criminal activity and some risky health behaviors, this data contributes to an understanding of the relationship between the nature of women's lives and their participation in risky health behaviors. Research since the collection of data for this study has highlighted the parallels between women involved in criminal activity and women at high risk for certain poor health outcomes. Most of this research has been focused on the reporting of discrete events and has not taken into account women's responses to such events. The life history narratives used in this study offered the unique

advantage of an infrequently used method for incorporating women's life events and their responses into the understanding of their risky health behaviors.

Conclusions

Although various life events were common among women in each risky health behavior category, there were no two combinations of life events and risky health behaviors that were identical in regards to their number, timing, and nature. What was common across all women in the study were descriptions of poor parenting, as demonstrated by lack of parental concern, supervision, protection, and, in some cases, physical and/or sexual abuse, parental alcohol and drug abuse, and domestic abuse. These findings suggest the need for early and tailored interventions aimed at assisting women whose lives parallel the lives depicted in this study.

Challenges in offering effective interventions for women with histories of trauma will continue to persist in light of varying conceptualizations and the array of assessment tools. Using a variety of tools to measure different aspects of abuse in research will provide the most thorough understanding of women's experience with abuse and lead to more meaningful clinical interventions. The strength of interventions aimed at preventing abuse and minimizing its sequelae are dependent upon solid research evidence derived from sensitive measurement tools and methods that accurately capture the woman's comprehensive experience of trauma (Smith et al., 1999). Research that strikes the delicate balance between capturing a broad experience of various types of trauma, as well as the specific nature of that trauma will provide the most comprehensive insight into the chaotic lives of women engaged in risky health behaviors.

Table 1.

Demographic Characteristics of Sample for the Study (N = 15)

Name ¹	Age	Race	Marital Status	Number of Children	Highest Grade Completed	Reason for Incarceration
Anne	28	Other	Never married	1	11	Drug possession
Brenda	26	White	Never married	1	10	Multiple charges ²
Carol	32	White	Common law	4	12	Selling drugs
Diane	29	White	Never married	0	14	Prostitution
Evelyn	31	Afr-Amer	Married	4	9	Drug possession
Francine	24	Mixed	Never married	2	9	Prostitution
Gayle	37	Afr-Amer	Common law	0	11	Disorderly conduct
Helen	27	White	Separated	0	12	Simple assault
Iris	26	White	Common law	0	12	Multiple charges ³
Jackie	20	White	Never married	0	9	Drug possession
Kate	38	White	Separated	2	12	DUI ⁴
Linda	23	Other	Common law	1	8	Prostitution
Mandy	41	White	Married	2	12	Drug possession
Nancy	33	White	Married	2	13	Selling drugs
Ophelia	33	Afr-Amer	Separated	2	12	Larceny/theft (>\$50)

¹ Pseudonyms

² Prostitution, disorderly conduct, assault & battery, breaking and entering, attempt to commit a felony, and larceny

³ Prescription forgery, drug possession, and possession of stolen credit cards

⁴ DUI=Driving under the influence

Table 2.

Summary of Variables Selected from Questionnaire Data

Demographics	Drug and Alcohol Use
Age	Age of first drug use
Race	Use of drugs before incarceration (yes/no)
Religion	Description of drug use
Marital status	Type of substance abuse treatments
Highest grade completed	Number of substance abuse treatment attempts
Dropped out of high school (yes/no)	Amount of money spent weekly on drugs
Grade dropped out of high school	Sources of drug money
Childhood SES	History of prostitution (yes/no)
Age at self-support	Age at first prostitution
Job before incarceration (yes/no)	Family members w/history of drug use
Adult work history	Number of family members who used drugs
Adult income source	
Children and Family	Criminal History
Number of children	Total number of offenses
Age at birth of first child	Sentence granted at time of interview
Ages of children	Time expected to serve
Child placement during incarceration	First, second, third, and fourth offenses
Childhood household members	Total number of adult incarcerations
Number of times ran away from home	Age at first incarceration
Number/type of childhood living situations	Age at first arrest
Number of siblings	Offense first arrest
	Juvenile incarcerations (yes/no)
	Family members ever incarcerated
	Number of family members ever incarcerated

Abuse and Trauma	Health Problems
History of physical abuse (yes/no)	Health problem or disability (yes/no)
Frequency of physical abuse	Mental health problem (yes/no)
Perpetrators of physical abuse	Eating disorder/weight problems (yes/no)
Frequency of violence between parents	
Childhood sexual activity (yes/no)	
Persons involved in child sexual activity	
Age at first sexual activity or abuse	
History of sexual abuse (yes/no)	
Duration of sexual abuse	
Perpetrators of sexual abuse	
Number of rape attempts/completed rapes	
Perpetrators of rapes	
Total number of rape situations	
Violent relationships	

Table 3.

Risky Health Behaviors in which Women Engaged

Risky Health Behaviors	<i>n</i>
Alcohol and/or Drug abuse	13
Sex Work/Prostitution	12
Early Initiation of Sexual Intercourse	7
Suicide Attempts	5
Multiple Sexual Partners	2

Table 4.

Reported Risky Health Behaviors by Age of Participation

Age	Risky Health Behaviors	<i>n</i>
<i>Preadolescence</i>		
11	Alcohol Use	2
	Marijuana Use	1
12	Alcohol Use	3
	Drug Use ¹	3
	Smoking cigarettes	1
	Marijuana Use	1
<i>Adolescence</i>		
13	Smoking cigarettes	1
	Early sexual intercourse	1
	Prostitution	1
	Marijuana Use	1
	LSD Use	1
	Shooting drugs ¹	1
14	Drug Use ¹	2
	Heroin/cocaine/speed/acid/THC	1
	Suicide Attempt	1
15	Early sexual intercourse	5
	Alcohol Use	2
	Drug Use ¹	1
	Shooting heroin	1
16	Multiple Sexual Partners	2
	Prostitution	2
	Early sexual intercourse	1

	Alcohol Use	1
	Drug Use ¹	1
	Shooting heroin/cocaine	1
17	Suicide Attempt	2
	Prostitution	1
	Cocaine Use	1
	Shooting drugs ¹	1
	Acid Use	1
	<i>Adulthood</i>	
18	Prostitution	2
	Shooting heroin	1
19	Marijuana Use	2
	Alcohol Use	1
	Prostitution	1
	Suicide Attempt	1
20	Prostitution	3
	Drug Use ¹	1
21		
22		
23	Suicide Attempt	1
	Shooting heroin	1
24	Prostitution	1
25	Suicide Attempt	1
	Prostitution	1
26		
27		
28		
29		

30	Cocaine Use	1
31	Suicide attempt	1
	Shooting heroin	1
32		
33		
34		
35		
36		
37	Suicide Attempt	1
38		
39		
40		

¹no specific drug indicated

68

Figure 1. Carol's life timeline: Serial/overlapping childhood disadvantage → Pre-adolescent onset of risky health behaviors.

Legend. DP = death of parent; OKE = other key event; FSI = first sexual intercourse; DU = drug use; Pros = prostitution; IPV = intimate partner violence; SUI = suicide attempt.

Note. DP1: father died of emphysema; OKE1: mother was hit by a truck [suspected suicide attempt]; OKE2: mother was hit by a truck again [suspected suicide attempt]; FSI: forced to have sex by group of guys; negotiated to have sex with only one; DP2: mother died [hit by truck]; suspected suicide; ↑DU: escalation in drug use: began shooting heroin; SUI: Attempted suicide by ingesting barbiturates; ended up in a coma.

06

Figure 2. Iris' life timeline: Serial/overlapping childhood disadvantage → Pre-adolescent onset of risky health behaviors.

Legend. OKE = other key event; SexAbus = sexual abuse; DU = drug use; MultSex = multiple sexual partners; Pros = prostitution; SUI = suicide attempt.

Note. OKE1: mother remarried; mother and stepfather began using drugs; SexAbuse: sexually abused by stepfather for 5 years; then developed "consensual" sexual relationship with him after; 1stDU: introduced to drugs by babysitter and babysitter's boyfriend; OKE2: mother attempted suicide by slitting wrists; 1stPros: first "real" prostitution for money; had slept with guys during teenage years for drugs and other things but not for money; OKE3: started selling drugs (marijuana and pills) at school; SUI: tried to commit suicide (took pills) after fight with boyfriend of 3 years.

91

Figure 3. Jackie's life timeline: Serial/overlapping childhood disadvantage → Pre-adolescent onset of risky health behaviors.

Legend. DP = death of parent; SexAbus = sexual abuse; OKE = other key event; 1stPreg = first pregnancy; DO = death of other; SexAssault = sexual assault; DU = drug use; Pros = prostitution; SUI = suicide attempt; IPV = intimate partner violence.

Note. DP: father committed suicide a few months after her birth; SexAbuse: sexually abused by uncle for 4 years; OKE: began spending time in a foster homes and other temporary living situations; 1stPreg: became pregnant and mother forced her to have an abortion; DO: uncle who molested her died; SUI: 3rd suicide attempt; placed in psychiatric hospital for 2.5 months.

Figure 4. Brenda's life timeline: Serial/overlapping childhood disadvantage + childhood turning point → Pre-adolescent risky health behaviors.

Legend. PhysAbuse = physical abuse; SexAssault = sexual assault; DP = death of parent; DU = drug use; FSI = first sexual intercourse; Pros = prostitution.

Note. SexAssault: kidnapped from corner, raped, brutally attacked, and almost killed by stranger; DP: mother died from heart attack.

63

Figure 5. Kate's life timeline: Serial/overlapping childhood disadvantage → Adolescent onset of risky health behaviors.

Legend. SexAbuse = sexual abuse; DS = death of sister; OKE = other key event; SexAssault = sexual assault; DO = death of other; ETOH = alcohol use; IPV = intimate partner violence.

Note. SexAbuse: fondled by father (older sisters were molested); DS: death of 5-year-old younger sister; OKE1: hospitalized for rheumatic fever for 2 months; was taken out of school for 2 years and tutored at home; SexAssault: fondled by man while babysitting for his family; DO: boyfriend killed in Vietnam—talking about this provoked tears during interview; OKE2: suffered two rape attempts—one from a stranger, one from an acquaintance.

94

Figure 6. Evelyn's life timeline: Serial/overlapping disadvantage + childhood turning point → Adolescent onset of risky health behaviors.

Legend. OKE = other key event; PhysAbuse = physical abuse; SexAssault = sexual assault; 1stPreg = first pregnancy; DU = drug use; Pros = prostitution.

Note. OKE1: witnessed uncle beat and killed during racially-motivated attack; SexAssault1: several rape attempts by friend of father, attempted rape by boss, and fondling by friend's sister; SexAssault2: raped twice in a matter of months by two clients.

95

Figure 7. Helen's life timeline: Isolated childhood disadvantage → Pre-adolescent risky health behaviors.

Legend. PhysAbuse = physical abuse; SexAbuse = sexual abuse; ETOH = alcohol use; DU = drug use; IPV = intimate partner violence; Pros = prostitution.

96

Figure 8. Anne's life timeline: Childhood turning point + Isolated childhood disadvantage → Pre-adolescent onset of risky health behaviors.

Legend. DU = drug use; FSI = first sexual intercourse; Pros = prostitution; IPV = intimate partner violence.

97

Figure 9. Francine's life timeline: Isolated childhood disadvantage → Adolescent onset of risky health behaviors.

Legend. DU = drug use; MultSex = multiple sexual partners; Pros = prostitution.

Poor parenting: Mother's
psychological abuse

86

Figure 10. Nancy's life timeline: Isolated childhood disadvantage → Adolescent onset of risky health behaviors.

Legend. DU = drug use; ETOH = alcohol use.

Note. ↑DU: started shooting drugs; DU: resumed IV drug use after being clean for three years.

66

Figure 11. Gayle's life timeline: Childhood turning point + Isolated childhood disadvantage → Adolescent onset of risky health behaviors.

Legend. PhysAbuse = physical abuse; Pros = prostitution; DU = drug use.

Note. PhysAbuse: started getting beat by stepfather; at age 12, he threw her down the stairs after accusing her of having sex; ↑DU: escalation in drug use after serving 2 years in prison; started shooting heroin.

Figure 12. Ophelia's life timeline: Isolated childhood disadvantage → Adolescent onset of risky health behaviors.

Legend: DU = drug use; ETOH = alcohol use; Pros = prostitution.

Figure 13. Diane's life timeline: Isolated childhood disadvantage + Adolescent turning point → Adolescent onset of risky health behaviors.

Legend. SUI = suicide attempt; DU = drug use; Pros = prostitution.

Note. DP: Mother died of cancer; SUI: Hospitalized after suicide attempt.

102

Figure 14. Linda's life timeline: Isolated childhood disadvantage → Adulthood onset of risky health behaviors.

Legend. Pros = prostitution.

Poor parenting: Mother's
psychological abuse

Figure 15. Mandy's life timeline: Isolated childhood disadvantage → Adulthood onset of risky health behaviors.

Legend. DU = drug use; SUI = suicide attempt.

Appendix A: On-Line Form for Permission to Access Data

[HOME \(HTTP://IQ.HARVARD.EDU/FRONTPAGE\)](http://iq.harvard.edu/frontpage) [POLICIES \(HTTP://IQ.HARVARD.EDU/POLICIES\)](http://iq.harvard.edu/policies) [CONTACT US \(HTTP://IQ.HARVARD.EDU/CONTACT-US\)](http://iq.harvard.edu/contact-us)

Quick Links

Find Data (<http://dvn.iq.harvard.edu/>)

Browse Original Murray Collection (<http://dvn.iq.harvard.edu/dvn/dv/mra>)

Deposit Data (<http://dvn.iq.harvard.edu/dvn/faces/login/CreatorRequestInfoPage.xhtml>)

Dissertation Grants (http://www.iq.harvard.edu/dissertation_awards)

Home (<http://iq.harvard.edu/>)

Application

Application for Data Use

Name: *

Address: *

City, State, Zip Code: *

Study Request 1

Study Contributor: *

Study Title: *

Study Identifier: *

Study Request 2 (#)

Study Request 3 (#)

Study Request 4 (#)

Digitization request: *

☐ I will use this data on-site

☒ Please digitize this data and make it available on-line (fees may apply)

2. Digitized materials will be delivered through our on-line system. Non-digital materials may be examined on-site for no cost, or may be digitized on demand for a fee (we will contact you with an estimate). Please refer to our Dataverse catalog for format availability.

3. I agree that if permission is granted, I will use the Data for the following purpose(s) and for no other purpose

Data use: *

☒ Secondary analysis of the Data

☐ Comparative study – comparing the Data with information from another data-set

☐ Follow-up study of the original sample

☐ Replication – administer measures to new sample

☐ Pilot data

4. A brief summary of my proposed areas of inquiry is provided below

Summary: *

(if you are applying for a Murray Archive grant, you only list the grant for which you are applying here)

File Submission: I am attaching a 1–2 page description of my proposed research project. (required):

no file selected

Applications cannot be approved without proposal.

(If applying for a Murray Archive grant, the grant proposal will suffice.)

Completion Date: *

(Month:) (Day:) (Year:)

The date I estimate I will complete my project by.

5. In using this data set I agree to abide by the following restrictions:

a. I hereby acknowledge that I have read the Memorandum of Agreement between the Henry A. Murray Archive, Harvard University and Data Contributors and Exhibit A relating to the Data requested.

b. I will honor all agreements and conditions made: (1) between the Contributor of the Data and the participants, and (2) between the Contributor of the Data and the Henry A. Murray Archive, Harvard University, (the "Archive"). These agreements and conditions are set forth in the Memorandum of Agreement between the Henry A. Murray Archive, Harvard University and Data Contributors, including Exhibit A thereto.

c. I will not knowingly divulge any information that could be used to identify individual participants in the study and I agree to use such precautions as are reasonably necessary to prevent such identification. If I suspect that I might know a study participant, I will immediately inform the Archive staff. If I recognize a study participant in the course of my research I will immediately ask the staff to remove that participant's data, and I will not use or retain a copy thereof.

d. I understand that prior written permission of the Director of the Archive is required for me either to reproduce any portion of the Data or to allow any other person or institution to examine the Data.

e. If any portion of the Data is to be published, I will place such copyright notice to protect the Data as may be required by the Director of the Archive.

f. When reports and/or publications are generated, I will make appropriate acknowledgment of the contributor as well as the Archive for use of the Data, and will include the citations listed under "How to Cite" in the data documentation.

g. I will send to the Archive one electronic copy and one "hard" copy of any report or publication based directly or indirectly on use of the Data.

h. Reproducing Research Materials (the Data): If this application includes a request for reproduction of any portion of the research materials listed above, I agree that the reproduction is to be made solely for my convenience in examining the research Materials for scholarly purposes; that it is to be returned upon completion of my work, but not later than 12 months after I receive the Data; that the reproduction will not itself be reproduced;

and that it will not be examined or transferred to any other person or institution without the prior written permission of the Director of the Archive. I agree to return all Materials to the Archive upon completion of the proposed research project, but not later than 12 months after I receive the Data. (If the Materials are needed for the research project for an additional time period, written permission must be first obtained from the Director of the Archive.)

BY TYPING MY NAME IN THE SPACE LABELED "SIGNATURE" BELOW (WHICH SHALL CONSTITUTE MY SIGNATURE) AND BY CLICKING ON THE "I AGREE" BUTTON BELOW, I CONFIRM (A) THAT I HAVE READ AND UNDERSTOOD EACH AND EVERY TERM SET FORTH ABOVE, (B) THE ABOVE REPRESENTATIONS AND THE INFORMATION I PROVIDE BELOW ARE ACCURATE, (C) THAT I HAVE THE AUTHORITY TO SIGN THIS FORM , AND (C) I AGREE TO BE BOUND BY THE ABOVE TERMS AND CONDITIONS, (D) AGREE NOT TO REPRODUCE ANY OF THE DATA, IN ANY FORM, WITHOUT PRIOR EXPRESS WRITTEN CONSENT OF THE DIRECTOR.

Signature: *

Affiliation:

Position:

Email : *

Phone: *

Submit

Appendix B: Correspondence Granting Permission to Access Data

HARVARD - MIT DATA CENTER

RT Self Service / #52714: Life Histories of Women in Prison, 1986-1987

The Basics

Id: 52714
Status: resolved
Left: 0 min
Priority: 1/100
Queue:
MRA_Task_Type: (no value)
Patron Community: (no value)
Needs user response: (no value)

Dates

Created: Mon Sep 10 12:35:56 2007
Starts: Not set
Started: Not set
Last Contact: Fri Jan 04 15:44:47 2008
Due: Mon Sep 17 12:35:56 2007
Closed: Fri Jan 04 15:44:47 2008
Updated: Fri Jan 04 15:44:47 2008 by Sonia

History

Display mode: Brief headers — Full headers

Mon Sep 10 12:35:57 2007 harrison@email.unc.edu [Reply] [Comment]
 - Ticket created

Subject: Life Histories of Women in Prison, 1986-1987

Date: Mon, 10 Sep 2007 12:35:54 -0400 (EDT)

To: mra_support@help.hmdc.harvard.edu

From: harrison@email.unc.edu

[Download \(untitled\)](#) [text/plain 1.6k]

Submitted on 09/10/2007 - 11:35

Submitted by anonymous user: [75.181.61.69]

Submitted values are:

Name: Nena Harris

Address: 2612 Boulder Lance

City, ST Zip Code: Charlotte, NC 28269

Study Contributor: Mary E. Gilfus

Study Title: Life Histories of Women in Prison, 1986-1987

Study Identifier: 00917

Digitization request: Please digitize this data and make it available on-line (fees may apply)

Data use: Secondary analysis of the Data

Summary:

The dataset "Life Histories of Women in Prison, 1986-87" will be used to assess the relationships between childhood abuse and trauma and HIV risk behaviors. Specifically, the research aims are: 1) to examine the role of childhood abuse and trauma in participation in HV risk

behaviors (i.e. substance abuse, prostitution) in women prisoners, 2) to examine the relationship between onset and severity of childhood abuse and trauma and the extent of participation in HIV risk behaviors in adulthood, and 3) to explore women's experiences with childhood abuse and trauma and their perceptions of the impact on their lives as adult women. Qualitative interviews will be closely examined for specifics about the nature of childhood abuse and trauma and HIV risk behaviors in order to provide a context for the information gathered by quantitative instruments. The data will be analyzed as a part of doctoral dissertation research.

Completion date: April 29, 2008

Signature: Nena Harris

Date: September 9, 2007

Affiliation:

UNC-Chapel Hill School of Nursing, Chapel Hill, NC

Position: Doctoral Student

Email: harrism@email.unc.edu

Phone: 919-451-0353

The results of this submission may be viewed at:

<http://www.murray.harvard.edu/application?sid=35>

#	Mon Sep 10 12:38:11 2007	Sonia - Correspondence added	[Reply] [Comment]
---	--------------------------	---	--------------------------

Subject: Re: [hmdc.harvard.edu #52714] harrism@email.unc.edu:
Life Histories of Women in Prison, 1986-1987 to queue
MRA

Date: Mon, 10 Sep 2007 12:38:05 -0400

To: mra_support@help.hmdc.harvard.edu

From: Sonia Barbosa <sbarbosa@hmdc.harvard.edu>
[Download sbarbosa.vcf](#) [text/x-vcard 389b]

[Download \(untitled\)](#) [text/plain 2.2k]

Your application has been received.

harrism@email.unc.edu via RT wrote:

```
> Transaction: Ticket created by harrism@email.unc.edu
> Queue: MRA
> Subject: Life Histories of Women in Prison, 1986-1987
> Ticket <URL:
https://help.hmdc.harvard.edu/Ticket/Display.html?
id=52714 >
>
>The last correspondence on this ticket was as follows:
>-----
>-----
>Submitted on 09/10/2007 - 11:35
>Submitted by anonymous user: [75.181.61.69]
>
>Submitted values are:
```


Mon Sep 10 15:09:33 2007 **Sonia - Taken**# Mon Sep 10 15:19:32 2007 **Sonia - Correspondence added** [Reply] [Comm]

Subject: Re: [hmdc.harvard.edu #52714] harrism@email.unc.edu: Life Histories of Women in Prison, 1986-1987 to queue MRA
Date: Mon, 10 Sep 2007 15:19:28 -0400
To: mra_support@help.hmdc.harvard.edu
From: Sonia Barbosa <sbarbosa@hmdc.harvard.edu>
[Download sbarbosa.vcf](#) [text/x-vcard]

[Download \(untitled\)](#) [text/plain]

Dear Nena:

You have been approved to use the Life Histories of Women in P Study.

Please visit the following website:

<http://dvn.iq.harvard.edu/dvn/faces/study/StudyPermissionsPage.jspx>

and log in using the following information:

username:

password:

This should give you access to the restricted computer and text that are available for this study. There are two boxes of paper files that you are also requesting, and again, you would be responsible

for the cost of digitization. Please let me know how you would like to proceed with the latter.

Don't hesitate to contact me if you have any problems accessing data on-line.

Best

Sonia Barbosa

Operations Manager

harrism@email.unc.edu via RT wrote:

> Transaction: Ticket created by harrism@email.unc.edu
> Queue: MRA
> Subject: Life Histories of Women in Prison, 1986-1987
> Ticket <URL: <https://help.hmdc.harvard.edu/Ticket/Display.html?id=52714> >
>
> The last correspondence on this ticket was as follows:
> -----
> Submitted on 09/10/2007 - 11:35
> Submitted by anonymous user: [75.181.61.69]
>
> Submitted values are:
> Name: Nena Harris
> Address: 2612 Boulder Lance

Appendix C: Institutional Board Review Approval

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

OFFICE OF HUMAN RESEARCH ETHICS
Medical School Building 52
Mason Farm Road
CB #7097
Chapel Hill, NC 27599-7097
(919) 966-3113
Web site: ohre.unc.edu
<https://my.research.unc.edu> for IRB status
Federalwide Assurance (FWA) #4801

To: Nena Harris
School of Nursing

From: Public Health-Nursing IRB

Trude Bennett
Authorized signature on behalf of IRB

Approval Date: 1/16/2009

Expiration Date of Approval: 1/15/2010

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

Submission Type: Initial

Expedited Category: 5.Existing or non-research data

Study #: 09-0021

Study Title: Life Course Pathways and Risky Health Behaviors in Incarcerated Women

This submission has been approved by the above IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Study Description:

Purpose: The purpose of the proposed study is to examine the life history pathways associated with risky health behaviors in the subset of women completing both the questionnaire and interview components of the Life Histories of Women in Prison, 1986-1987 study. Participants: Fifteen incarcerated women who completed both the questionnaire and life history interview components of the parent study will constitute the sample for the proposed study. Procedures (methods): The data for the proposed study will be analyzed using a person-centered analysis, which focuses on the distinctive variations in individuals' lives and involves the depiction of life events mapped across the life span.

Regulatory and other findings:

This research meets criteria for a waiver of informed consent according to 45 CFR 46.116(d).

Investigator's Responsibilities:

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

When applicable, enclosed are stamped copies of approved consent documents and other recruitment materials. You must copy the stamped consent forms for use with subjects unless you have approval to do otherwise.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification form at ohre.unc.edu/forms). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the adverse event form at the same web site.

Researchers are reminded that additional approvals may be needed from relevant "gatekeepers" to access subjects (e.g., principals, facility directors, healthcare system).

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

CC:

Margarete Sandelowski, School Of Nursing

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

OFFICE OF HUMAN RESEARCH ETHICS
Medical School Building 52
Mason Farm Road
CB #7097
Chapel Hill, NC 27599-7097
(919) 966-3113
Web site: ohre.unc.edu
<https://my.research.unc.edu> for IRB status
Federalwide Assurance (FWA) #4801

To: Nena Harris
School Of Nursing

From: Public Health-Nursing IRB

Authorized signature on behalf of IRB

Approval Date: 12/15/2009

Expiration Date of Approval: 12/14/2010

RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)

Submission Type: Renewal

Expedited Category: 5.Existing or non-research data

Study #: 09-0021

Study Title: Life Course Pathways and Risky Health Behaviors in Incarcerated Women

This submission has been approved by the above IRB for the period indicated.

Study Description:

Purpose: The purpose of the proposed study is to examine the life history pathways associated with risky health behaviors in the subset of women completing both the questionnaire and interview components of the Life Histories of Women in Prison, 1986-1987 study. Participants: Fifteen incarcerated women who completed both the questionnaire and life history interview components of the parent study will constitute the sample for the proposed study. Procedures (methods): The data for the proposed study will be analyzed using a person-centered analysis, which focuses on the distinctive variations in individuals' lives and involves the depiction of life events mapped across the life span.

Regulatory and other findings:

This research meets criteria for a waiver of informed consent according to 45 CFR 46.116(d).

Investigator's Responsibilities:

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

When applicable, enclosed are stamped copies of approved consent documents and other

recruitment materials. You must copy the stamped consent forms for use with subjects unless you have approval to do otherwise.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the modification form at ohre.unc.edu/forms). Any unanticipated problem involving risks to subjects or others (including adverse events reportable under UNC-Chapel Hill policy) should be reported to the IRB using the web portal at <https://irbis.unc.edu/irb>.

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40CFR 26 (EPA), where applicable.

CC: Margarete Sandelowski, School Of Nursing

Appendix D: Questionnaire and Interview Guide from Parent Study

WOMEN'S HEALTH & LEARNING CENTER

QUESTIONNAIRE

"Life Patterns of Women in Prison"

ID#: _____

Date: ____/____/____

1. What was your age at your last birthday? _____.

2. What religion were you raised? _____.

3. Please state your race or ethnic background: _____.

4. What is your current marital status?

____ 1. currently married

____ 2. common law marriage or live-in lover

____ 3. separated

____ 4. divorced

____ 5. single, never married

____ 6. widowed

5. How many children do you have? _____.

6. What age were you when you had your first child? _____.

7. Please list the age and sex of each of your children:

1. ____/____ 2. ____/____ 3. ____/____ 4. ____/____
(age) (sex) (age) (sex) (age) (sex) (age) (sex)5. ____/____ 6. ____/____ 7. ____/____ 8. ____/____
(age) (sex) (age) (sex) (age) (sex) (age) (sex)9. ____/____ 10. ____/____
(age) (sex) (age) (sex)

ID#: _____

-2-

Questionnaire

8. Where are your children living while you are in prison?

____ 1. with their father(s)	____ 5. with friends
____ 2. with other relatives	____ 6. in institutions
____ 3. in foster homes	____ 7. on their own
____ 4. in adoptive homes	____ 8. other: _____

(please check all that apply)

9. For what offense(s) are you currently incarcerated

(please do not include parole violations):

_____.

10. What is the official length of your sentence(s)?

_____.

11. What date did this incarceration begin (you may count time served in ATU): _____.

12. What is the earliest possible date you could be released or paroled? _____.

13. How many times have you been incarcerated as an adult? _____.

14. At what age was your first adult incarceration? _____.

15. What age were you the very first time you were ever arrested? _____.

16. What were the charges for your first arrest?

_____.

17. Were you ever incarcerated in a juvenile detention facility? ____yes ____no

If yes, how many times? _____.

ID#: _____

-3-

Questionnaire

18. At what age did you begin to think of yourself as an adult? _____.
19. At what age did you begin to support yourself financially? _____.
20. How did you earn money to support yourself at that age? _____.
21. At what age did you leave home (the home that you grew up in most of the time)? _____.
22. Did you ever run away from home, or from where you were supposed to be living, before age 17?
____yes _____no
If yes, at what age did you first try to run away? _____.
How many times would you say that you tried to run away? _____.
23. Up until you left home for good, please check all of the people you lived with:
____ 1. both parents	____ 6. other relatives
____ 2. mother only	____ 7. foster homes
____ 3. father only	____ 8. institutions
____ 4. mother & step-father(s)	____ 9. other: _____
____ 5. father & step-mother(s)	_____
24. Please list the ages of your brothers & sisters; include half or step siblings if they ever lived with you:
- Brothers: 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____
- Sisters: 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____

ID#: _____

-4-

Questionnaire

25. When you were still living at home, in your opinion, did any of the following people have a problem with drugs or alcohol? (check all that apply):

☐ 1. mother	☐ 5. brother(s)
☐ 2. father	☐ 6. sister(s)
☐ 3. a step-parent	☐ 7. other relative(s)
living with you.
☐ 4. guardian or
foster parent	☐ 8. other person living
with you.

26. Have any other members of your family or anyone you've lived with ever been incarcerated? ☐ yes ☐ no.

If yes, please check all that apply:

☐ 1. mother	☐ 6. brother(s)
☐ 2. father	☐ 7. sister(s)
☐ 3. a step-parent	☐ 8. your children
☐ 4. your husband or
lover	☐ 9. other person living
with you.

27. While you were growing up how would you describe your family's financial situation?

- ☐ 1. we were on welfare a lot of the time.
- ☐ 2. we were not on welfare but we seemed poor.
- ☐ 3. my parent(s) worked hard and we got by okay.
- ☐ 4. we were pretty comfortable, maybe middle class.
- ☐ 5. we were very well off.
- ☐ 6. other: _____.

Id#: _____

-5-

Questionnaire

28. While you were growing up, did anyone in your household ever severely punish you or abuse you (such as using hard punches/slaps, kicking, throwing you, throwing objects at you, using weapons to threaten you, etc.)?

____ yes ____ no

If yes, how often did any of these things happen?

____ 1. only once ____ 2. a few times

____ 3. often ____ 4. very often

29. If you answered yes to the previous question, check all of the people who were involved in severely punishing or abusing you as a child:

____ 1. mother

____ 6. brother(s)

____ 2. father

____ 7. sister(s)

____ 3. a step-parent

____ 8. other person living
with you.

____ 4. guardian or
foster parent

____ 5. other relative(s)

30. Did your parents, step-parents, guardians or foster parents ever engage in physical violence with each other?

____ 1. no, never ____ 2. yes, only once

____ 3. yes, some times ____ 4. yes, very often

31. When you were a child do you remember anyone ever trying to engage you in sexual activity, such as touching, masturbation, watching you nude, showing you sexual pictures, trying to have intercourse with you, etc.?

____ yes ____ maybe ____ no ____ do not wish to answer.

ID#: _____

-6-

Questionnaire

32. Please try to think back and remember all of the different people who tried to involve you in sexual activity when you were a child:

____ 1. a stranger	____ 8. sister(s)
____ 2. adult neighbor	____ 9. step-parent
____ 3. playmate your age	____ 10. father
____ 4. babysitter	____ 11. foster family member(s)
____ 5. male cousin(s)	____ 12. other relatives (aunts, uncles, grandfather, etc.).
____ 6. brother(s)	____ 13. teacher, minister, etc.
____ 7. female cousin(s)	____ 14. other: _____

At what age were you the first time any one of the above people tried to engage you in sexual activity? _____.

33. Would you say that you were sexually abused, molested or the victim of incest?

- ____ 1. yes ____ 2. not sure ____ 3. no ____ 4. do not wish to answer.

If you were, at what age did the sexual abuse begin? _____.

If yes, at what age did the sexual abuse end? _____.

If yes, how many different people sexually abused you? _____.

34. As a teenager or adult, has anyone ever tried to rape you or force you to have sex against your will?

- ____ yes ____ no.

ID#: _____

-7-

Questionnaire

35. As a teenager or adult, how many times has someone tried to rape you but did not succeed? _____.
36. As a teenager or adult how many times has someone actually succeeded in raping you? _____.
37. Please check all the situations where someone has tried or succeeded to rape you:
____ 1. a stranger	____ 7. police officer(s)
____ 2. a group of strangers	____ 8. customer(s)
____ 3. an acquaintance	____ 9. an employer
____ 4. a lover or date	____ 10. a doctor or other professional person.
____ 5. a relative	
____ 6. your husband	____ 11. other: _____.
38. As an adult, have you ever been in relationships which have involved physical violence? (check all that apply):
____ 1. yes, with a husband	____ 4. yes, with my children
____ 2. yes, with a lover	____ 5. yes, with someone else
____ 3. yes, with a friend	____ 6. no, never.
39. What is the highest grade of schooling that you have finished? _____.
40. Did you drop out of school before finishing high school? ____yes ____no.
- If so, what grade were you in when you left? _____.
41. Have you ever gone back for more education?
- ____no ____yes. What kind? _____.

ID#: _____

-8-

Questionnaire

42. Before this incarceration were you working in a legal paying job? ____yes ____no.
43. How would you describe your work history?
- ____1. I've never had a legal paying job.
 - ____2. I've worked off and on but not all the time.
 - ____3. I've always held a legal paying job.
 - ____4. I consider myself a full-time mother & homemaker.
 - ____5. other: _____.
44. When you have had legal paying jobs, what kind of work have you done most of the time? _____.
45. How do you usually support yourself financially?
- _____.
46. At what age did you first try using drugs or alcohol? _____.
47. Were you using drugs or alcohol regularly before this incarceration began? ____yes ____no.
48. How would you describe your drug and alcohol use?
- ____1. I have never used drugs or alcohol.
 - ____2. I sometimes use drugs or alcohol but do not consider them a problem for me.
 - ____3. I was addicted to drugs but have been drug-free for how long? _____.
 - ____4. I was an alcoholic but have been sober for how long? _____.
 - ____5. I am addicted to drugs.
 - ____6. I am an alcoholic.

ID#: _____

-9-

Questionnaire

354

49. How much money do you spend in an average week for drugs or alcohol? _____.
50. How do you usually earn money for drugs or alcohol? _____.
51. Have you ever worked as a prostitute? ____yes ____no.
If yes, how old were you when you first began? _____.
52. Have you ever been in a drug or alcohol treatment program (check all that apply):
____1. A.A. or N.A. ____4. Methadone maintenance
____2. outpatient counseling ____5. detox program
____3. residential program ____6. None.
53. What kind of treatment program has helped you the most? _____.
54. Do you have any physical disability or serious health problem? Please describe: _____
_____.
55. Do you feel that you have any kind of mental health problem? Please describe: _____
_____.
56. Do you feel that you have any type of eating disorder?
____1. extreme overweight
____2. extreme underweight
____3. eat a lot and then vomit
____4. other (describe): _____

ID#: _____

-10-

Questionnaire

57. Would you like to be selected for an interview
as a part of this study? ___yes ___maybe ___no.

THANK YOU

All information that you have shared here will remain
completely confidential so please do not write your
name anywhere on this form.

If you would like to make any comments or add any
information or if you feel we left out any important
questions, please write your comments on the back of
this form.

If you wish to talk with someone about any of the
questions we have asked you or would like help with
any problem please contact the Women's Health and
Learning Center.

Thank you for your help in helping us better
understand the lives and needs of women in prison.

Women's Health & Learning Center

INTERVIEW GUIDELINES"Life Patterns of Women in Prison"

1. The life history interview can be completed in approximately three hours. An effort should be made to cover all questions but these guidelines should be viewed only as guidelines. Each respondent should be encouraged to tell her own life story, within relevant topical areas, as she recalls it and in her own language. The interviewer can inject relevant questions or probes as the respondent proceeds.
2. It is important that the interviewer obtain the ages at which each respondent experienced the life events discussed in the life history. Recall of the timing of events can be assisted by helping the respondent order events (e.g. did this happen before or after another event; what grade were you in then; where were you living then, etc.).
3. The focus of each interview should be first on obtaining a history of life events, both normative types of developmental events (such as beginning and ending school, leaving home, marriage, etc.) and crisis or derailment events (deaths, divorces, and other traumatic experiences).
4. The second focus for each interview is on experiences of violence throughout the life course: childhood sexual abuse, rapes and attempted rapes, battering, sexual harrassment, and so forth.
5. A third focus should be on the "deviant career path", beginning with earliest experiences of delinquent or deviant behaviors such as running away, stealing, substance abuse and prostitution. Try to get a sense of motivation, people who influenced her, and the progression of involvement in illegal activity. Specifics about arrests and incarcerations will be obtained from CORI records, so this can be only briefly covered in the interview.
6. The order or sequence of the interview can proceed as you and the respondent see fit, but I have found that it is helpful to begin in early childhood and work up to adolescence, then focus for substantial time on adolescence (usually when many problems began), and continue into adulthood. Be on the alert for memory gaps which could be clues to a history of incest or sexual abuse.
7. Check all tape recording equipment every time it is turned on or off to make sure you are recording.

QUESTIONS TO INCLUDEI. Family History.

- A. Composition & mobility: beginning at birth and up until respondent left home; who lived in the household, ages of siblings, parental marriages/divorces/separations, family moves, deaths and absences of significant people.
- B. Family economic status: source of income, parental work patterns, welfare, etc.
- C. Parental background: incarcerations, mental illness, drug/alcohol use, physical illness/disability. Race, ethnicity, religion may be important to discuss.
- D. Siblings: births, deaths, illnesses, incarcerations, drug/alcohol use, quality of relationships with respondent. Question when appropriate about physical and/or sexual abuse of siblings or by siblings.
- E. Placements/separations: Foster homes, adoptions, living with other relatives, etc. Look for abuse in foster homes and other placements.
- F. Quality of family relationships: Between parents, each parent and respondent, between siblings, etc. Who was respondent close to?
- G. Family violence: Was there physical violence between parents or one parent and her/his partners? Recall specific episodes of violence? Abuse or severe punishment of respondent and siblings: when, how often, describe incidents, how severe, did anyone intervene, how did respondent feel about it and cope with it?
- H. Emotional Abuse & Labeling: Explore for what parents said to her, name calling, put downs, mental torture, consistency and appropriateness of discipline, lack of affection, physical neglect, etc.

II. Respondent's Developmental History:

- A. Health: childhood illnesses, disabilities, hospitalizations? R's feelings about them, family handling of illnesses, peer responses to R's health/disability. Probe for hospitalizations related to injuries/abuse. Mental health, treatment, etc.
- B. School: Age at beginning, how she liked school, how she got along with other children & with teachers, did she have academic trouble, ever held back any grades, did she get any help with school problems? Did she skip school, when did that begin? Why? What grade and age did she leave school? Continue into adulthood: did she ever go back for more education, what kind, when.
- C. Friends: Did she make friends as a child? What kind of friends did she choose? Did she feel like an outsider with peers? Was there any one she especially looked up to? Felt close to?
- D. Goals: What did she want to be when she grew up? Who did she admire & want to be like? What did her parents want/expect her to be/do when she grew up?
- E. Sexual Development: Age at first period, what that was like, her feelings, was she prepared, who did she turn to. Did she have any sex education? Family attitudes toward sex?
Age at first sexual relationship, was she pressured/coerced, how she felt about it.

III. Childhood Sexual Abuse:

- A. Does she recall anyone ever trying to engage her in sexual activity as a child? Explore touching, pictures, uncomfortable hugs/kisses, etc. Explore brothers, father, step-father, cousins, uncles, babysitters, neighbors, friends, strangers.
There may be many episodes, so explore each one & continue until all have been discussed.
For each episode note age at beginning & ending, relationship to perpetrator, type of sexual activity, use of force or threats or favors, how respondent felt & interpreted it, how she tried to stop it, whether she ever told anyone, did anyone try to help her
Offer support, allow time to deal with feelings, may need to stop or move on and then return later to this topic.

- B. Explore the effects of any incidents of sexual abuse, such as: feelings about herself, self-esteem, carrying a secret, anger, relationships with family & peers, feelings about sex & her body.

Explore what happened in her life right after the abuse began: illnesses, school problems, nightmares, running away, stealing?

Note: some of those behaviors may be talked about earlier & exploring what happened before those events may help bring out sexual abuse.

Be alert to memory gaps as possible clues to sexual abuse.

IV. The Delinquent Career:

- A. Running Away: first time? Reasons, what was happening at home, where did she go & what did she do. Did she get caught? Or return? How many times did she run away?
When did she leave home for good? Where did she go & how did she support herself?
- B. Stealing: Did she ever steal anything as a child or teenager? Age at beginning, did it continue, what did she feel were her motives, did she get caught, family reactions. Has it continued?
- C. Drug/Alcohol Use: Age at first use, circumstances of first use, who influenced her, her motives. History of substance abuse: progression of frequency of use, types of substances, use of needles, making money for drugs, involvement with other users, addiction, illnesses and losses associated with drugs, efforts at treatment (dates, types of programs, what worked and what failed).
- D. Prostitution: Ever worked as a prostitute? Age at first trick. Circumstances of beginning, where was she, who was she with, her motives, how she felt about it, did she have a pimp, any use of violence or force to make her work? Did/does she have to be high to work? Any venereal diseases, pregnancies, violence with customers/pimps?
- E. First Arrest: age, offense(s), conviction? Did she ever get sent to juvenile detention facilities: ages, number of times, escapes, how they treated her, any help there?
- F. Adult: arrests & incarcerations, her sense of why she gets in trouble, her commitment to an illegal career, what attracts her to it.

V. Adult History: (in less detail than childhood & adolescence).

A. Childbearing: pregnancies, abortions, births, ages of children, placements, issues as a mother, strengths as a mother, losses of children or serious problems of children (health, sexual abuse, etc.).

B. Relationships: (especially explore for violence)--Chronology of significant love relationships (men & women), marriages/co-habitations. Describe each partner, involvement in crime & substance abuse, episodes of battering & sexual abuse. How does respondent handle relationships, what is she searching for, how she handles violence. Has she ever used shelters or social service agencies?

C. Work History: Respondent's work history, first job, regularity of work, types of jobs, problems with jobs, reasons for leaving jobs, financial issues. Her goals for work in the future?

Note: work history & criminal career may flow together--how she earns money, work as prostitute, stripper, etc.

Inquire about sexual harassment in jobs.

D. Rape & Sexual Harassment: Does she feel she has ever been raped or victim of attempted rape? May need to explore for times when she felt forced to have sex against her will. There may have been many episodes of rape/attempts & need to explore until all have been discussed. Some women minimize rape & sexual harassment, especially "day to day" incidents with police, customers, boyfriends, etc.

For each episode, note age at occurrence, perpetrator, circumstances, her efforts to avoid being raped and/or killed, how it affected her, whether she sought help/pressed charges & responses of people she turned to.

Sexual harassment: police, customers, employers, professionals, especially in drug treatment programs, prison workers & inmates.

Note: incestuous relationships may have begun or continued into adulthood, so explore this too.

E. Adult Outcomes of Family: Current relationships with parents & siblings, adult outcomes of siblings, family support of respondent.

F. Self: How she views herself, what she sees as her strengths & problems, her dreams for the future. What she thinks might have made her life turn out differently

Close interview with time to reflect back, support for painful feelings, prepare for dealing with memories.

Appendix E: Publications Produced from the Original Data

Brady, L.C. (2006). Consistency of trauma narratives and descriptions of self among incarcerated women. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 67(1-B), 531.

Abstract: Schemas are cognitive structures that develop through experience and process information throughout the lifespan. Refined definitions for schema exist but few studies have produced measurement methods useful in naturalistic settings. Language analysis is an easily accessible indication of schema processing. Tools to assess linguistic properties or emotional patterns have not been employed to determine schema patterns. This study proposed that linguistic and emotion properties were indicative of schema processing and would be correlated in trauma and self narratives. An archived data set of 21 life history interviews originally collected in the mid-1980's from 13 European American and 8 African American women prisoners was used to examine the question. Statements relating to childhood trauma and adult self descriptions were isolated within the original narratives and used as the basic unit of analysis. Theme analysis for emotions was utilized and 11 emotions were targeted based on findings and definitions first outlined by Lisak (1997). Language properties were isolated and tracked using a computer software program developed by Pennebaker, Booth, and King (1999) as a measure of individual differences in language expression. Values for each of four linguistic properties (Positive Emotion, Negative Emotion, Causation, Insight) and for each of 11 emotional themes (Anger, Fear, Betrayal, Loss, Legitimacy, Helplessness, Isolation, Guilt, Shame, Negative Self, Negative Other) were calculated for each interviewee and organized by statement type. Correlations of these values were then calculated between trauma and self statements to test whether similar patterns of response would be detected across statement type. While fewer predicted correlations were detected than anticipated, the general trend that emotion themes and language properties would be related was supported in this investigation. Specifically support was found for the language variable Insight and for the emotion variable Legitimacy across statement types. Comparisons of the individual profile of emotion themes within self and trauma statements revealed that for some participants a consistent pattern of emotion was detected. Further analyses comparing these profiles to the behavioral content of life narratives suggests that tracking emotional and behavioral patterns across the life narrative may be useful in expanding schema detection with naturalistic data.

Gilfus, M. (1987). *Life histories of women in prison*. Paper presented at the Third National Family Violence Research Conference, University of New

Hampshire.

Gilfus, M. (1989). Seasoned by violence/tempered by love: A qualitative study of women and crime. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 49(9-A), 2843.

Abstract: Female offenders have received only marginal attention in the field of crime and corrections. Women's patterns of crime are very different from men's. Women comprise only 5% of the nation's prison population and women commit only 10% of all violent crimes.

The patterns of women's crimes have changed very little over time. Women's crimes remain traditional "female" offenses: larceny, check fraud, prostitution, and drug-law violations. Very little data exist on female offenders and criminology theory has made little progress in explaining women's patterns of criminal activity.

This qualitative study brings three streams of recent scholarship to bear on the study of women and crime: life course theory, the new psychology of women, and family violence research. The study examines in depth the life histories of a sample of women in prison and develops a theoretical model for understanding the factors which both motivate and limit women's participation in crime.

Data were obtained from 96 questionnaires and 21 life history interviews with women incarcerated at the Massachusetts Correctional Institution at Framingham from 1985 to 1987.

Qualitative analysis of interview data, supplemented by questionnaire data, reveals that the women studied were exposed to extraordinary levels of childhood violence and stress: physical abuse, sexual abuse, neglect, parental alcoholism, and environmental deprivation related to poverty and racial discrimination. Those childhood stresses resulted in derailed developmental patterns including teenage pregnancy, disrupted education, running away from home, drug addiction and psychological vulnerability to repeated victimization. Entry into illegal activity was motivated both by lack of economic opportunities and recruitment into illegal street work through relationships with men.

Findings point to the role of family violence and social deprivation in motivating women toward crime while women's commitments to caretaking relationships limit the scope of women's participation in crime.

Policy implications of the study suggest that alternative sentencing programs for female offenders be developed according to a needs-based model. Programs should include treatment for addiction, recovery from trauma related to victimization, and educational and vocational opportunities. Broader policy questions regarding the legal system's response to inter-personal violence are discussed.

Gilfus, M. (1992). From victims to survivors to offenders: Women's routes of entry and immersion into street crime. *Women and Criminal Justice*, 4(1), 63-89.

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