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Bridging the Power Gap
Narrative Therapy With Incarcerated Women

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Social work intervention with incarcerated female clients is complicated by the oppressive patriarchal structures under which most jails and prisons operate, the victimization histories, and the various psychosocial problems with which female clients frequently present. Traditional ways of working with this mostly minority population often fail to challenge the profound effects of self-destructive behaviors, the internalized pathologizing self-discourse, and the oppressive societal ideologies that frequently characterize the lives of incarcerated women. This article argues for a new intervention paradigm for social work practice with incarcerated women while recognizing the implicit dictates of the correctional setting. It explores the philosophical foundations of the narrative therapy approach and demonstrates the clinical application of narrative strategies to social work intervention with women within a correctional context.

Keywords: incarcerated women; strengths perspective; narrative therapies; criminal justice; incarceration; jail

Powerlessness is ubiquitous in the lives of incarcerated women and remains a harsh reality in their experiences with the criminal justice system and its allied health and mental health services. Furthermore, incarcerated women frequently present with a myriad of medical, psychological, and social problems. The most frequently cited problems are substance abuse, mental illness, HIV/AIDS, sexual and physical violence, homelessness, family fragmentation, persistent poverty, and social isolation. As a result of such problems, jailed women often wrestle with feelings of guilt, self-condemnation, depression, shame, and doubt. Noting the multiple challenges with which most offenders present, Mattick (1974), as early as 1974, argued that jails had become a receiving facility for a host of disguised health, welfare, and social problem cases.
The female prison population has risen dramatically, up from 44,065 in 1990 to 96,099 in June 2002 (Bureau of Justice Statistics [BJS], 2002). Furthermore, the rate of growth for female inmates continues to exceed that of male inmates. Since 1995, the annual growth rate in the female inmate population has averaged 5.4%, higher than the 3.6% average increase rate of male inmates. Also, women accounted for 6.7% of all inmates at midyear 2002, up from 6.1% at year-end 1995 (BJS, 2002).

Incarcerated women are mostly poor, uneducated, unskilled, single mothers, with a disproportionate number being women of color. Black females, with a prison and jail rate of 349 per 100,000, were found to be 2½ times more likely than Hispanic females (137 per 100,000) and 5 times more likely than White females (68 per 100,000) to be incarcerated in 2002 (BJS, 2002). This stands in contrast to the fact that Black women make up only 14% of the U.S. female population and Hispanic women only 12%. Reporting on the characteristics of incarcerated women, BJS (2002) shows that an estimated two thirds have children younger than 18; 50% had used alcohol, drugs, or both at the time of their arrest; and almost 60% in state prisons report that they were physically and/or sexually assaulted at some point in their lives before the current incarceration.

Victims of childhood sexual abuse are likely to suffer the effects of post-traumatic stress disorder (PTSD)—a debilitating malady characterized by a cyclical pattern of recurrent intrusive thoughts and images of the abuse, followed by periods of avoidance of any reminders of such abuse. PTSD causes its sufferers to react behaviorally to memories of abuse with intense fear, hypervigilance, irritability, and exaggerated startle response or with feelings of detachment, emotional numbing, a restricted range of affect, and a sense of foreshortened future (Pietrzak, 1998). Affective numbing, whereby trauma survivors fail to feel their own feelings and anesthetize themselves to additional pain, is a powerful defense mechanism that is often augmented by drugging and drinking (Courtois, 1988). Some women even report that the only time they feel normal—free of painful thoughts and memories—is when they are high from drugs or alcohol (Harris, 1996). In addition to substance abuse, research also shows that women in prison have experienced unusually high rates of extremely abusive discipline from parents and prostitution, whether they are in prison for these crimes or not (Bunch, Foley, & Urbina, 2001). Another disturbing aspect of women and girls’ confinement is the relatively high rate of self-mutilation. Some speculate that incarcerated women’s disproportionately high suicide attempts (e.g., Miller, 1994), cell destruction, and self-mutilation are a result of women’s tendency to internalize anger, whereas incarcerated men are more likely to externalize anger by assaulting other prisoners or prison staff (Belknap, 2001).
The majority of incarcerated women are sentenced for nonviolent offenses such as prostitution, fraud, or drug-related crimes (U.S. Department of Justice, 1991), suggesting that poverty and addiction are strong motivators of their criminal behavior. In general terms, these women are not from mainstream America; many come from deprived and unstable backgrounds, have been extensively abused over time, and face significant financial, psychological, emotional, and social barriers in their efforts to reintegrate into their local communities (McCoy, Inciardi, Metsch, Pottieger, & Saum, 1995).

Incarcerated women are frequently stereotyped and systematically condemned by society. According to Singer, Bussey, Song, and Lunghofer (1995), they are often seen as “expendable,” “evil,” “women gone bad,” “not really women,” and “incapable of change.” Van Wormer (2001) locates such societal disdain for incarcerated women on factors such as America’s punitive ethos, vestiges of Puritanism, authoritarian patriarchal tendencies, and a natural tendency toward blaming the victim. For many of these women, being labeled a criminal frequently means being rejected by family and friends, employers, and society as a whole. The stigma associated with this devalued position often compounds issues of low self-esteem, guilt, anger, shame, passivity, dependency, and learned helplessness.

The harshness of women’s prison experience is likely to increase their feelings of isolation. Scores on the Multidimensional Scale of Perceived Social Support administered by Singer et al. (1995) revealed perceptions of minimal support among them. In addition, these women described themselves as feeling lonely and isolated. The authors note, further, that despite the dehumanizing experiences of addiction, prostitution, street life, and incarceration, the women were seeking support, understanding, and nurturance. They argue the need for supportive counseling throughout women’s involvement in the criminal justice system. Although incarceration is a serious disruption that undermines structures of everyday life, with appropriate intervention it can bring about fundamental rethinking and reconstruction of women’s lives.

**Toward An Empowerment-Based Intervention Practice Model**

Jails and prisons operate as coercive institutions with legitimate power of restricting behaviors and maintaining control through rigid regulatory systems. To many incarcerated women, the structures of this system mirror the oppressive conditions that have fostered their deviant lifestyles. Banks (2003) identifies a wide range of adverse features that make up life in
women’s prisons—factors that are likely to severely affect the health and well-being of incarcerated women. These include loss of freedom and consequent claustrophobia, endless and mind-numbing boredom of daily routine in confinement, strict limitations imposed on movement, states of nervousness and anxiety engendered by being constantly under the scrutiny and supervision of others, physical and emotional problems that go with withdrawal from substance or drug abuse, and absence of an advocate to deal with concerns and needs. Other factors identified include lack of privacy, endless lineups to be counted and checked, being punished for minor infractions, the fear of being placed in isolation as punishment, the unending noise and clamor that accompanies the custodial environment, the dependency that prison promotes and encourages, and, perhaps most important, never being sure of your release date and being always conscious that others who control you often have the right to influence that point in time.

Despite the resulting sense of powerlessness and debasement that often accompanies life within correctional settings, a 1999 report by the General Accounting Office entitled “Women in Prison: Issues and Challenges Confronting U.S. Correctional Systems” (cited in Van Wormer, 2001, p. 242) found serious deficiencies in women’s treatment in areas of substance abuse, mental health problems, and HIV infection. Compared to men, women in prison have higher rates of illnesses in all three areas. For mental illness, for example, 13% of female inmates in federal prisons and 24% in state prisons report having a mental disorder or having spent time in a mental hospital (compared to 7% and 16%, respectively, for men). Of all three areas, substance abuse treatment was identified as the most deficient. Although 70% to 80% of female inmates today have substance abuse problems, only about one fourth of them receive the treatment they need. Van Wormer (2001) argues further that allegations from female inmates and their legal advocates demonstrate medical abuse and neglect. They include allegations of the denial of adequate medicine for chronic diseases, lack of timely treatment for spreading cancers, and dangerous delays in the care of pulmonary and cardiac problems. The challenges faced by practitioners in correctional settings are quite complex. Faced with clients, many of whom suffer from a vast array of co-occurring disorders, practitioners must seek to identify and utilize intervention approaches that will help these women discover their areas of strength, challenge their devalued internalized status, and find courage and hope.

Currently, clinical intervention within the largely male-dominated correctional system is based on clinical wisdom derived from traditional positivistic theories. Many of these theories lack both cultural and gender relevance to this predominantly minority female population and tend to pathologize rather than empower them. Furthermore, the strategies that undergird
many of these theories are authority based, further reinforcing feelings of powerlessness.

**Narrative Therapy as a Source of Empowerment and Change**

Narrative therapy, with its postmodernist assumptions about power, knowledge, and truth, can be a primary vehicle for helping the multiproblem female inmate become more efficacious. Feelings of hopelessness, loss of control, and disillusionment that frequently characterize the life of incarcerated women can be challenged in a very empowering, self-directed, and respectful way, thereby increasing their ability to regain a sense of direction in their lives.

The narrative approach parallels many of the philosophical underpinnings of clinical practice—specifically its concern for human dignity, equity, and self-determination. In addition, it emphasizes strength rather than pathology and recognizes the effect of oppressive societal forces on individual functioning. Its emphasis on understanding and meaning is especially useful for practitioners working with diverse clients and vulnerable populations (Kelly, 1996). White (1995) notes that narrative practice is more than a set of techniques; it is grounded within a system of beliefs that frame the way help is offered. Freedman and Coombs (1996) identify the following four ideas as central tenets of the narrative approach to treatment: reality is socially constructed, reality is socially constructed through language, reality is organized and maintained through narrative, and there are no essential truths. The following discussion demonstrates the applicability of these ideas to the female inmate population.

**Social Construction of Reality**

The social construction of reality describes how ideas, practices, and beliefs come to have reality status in a given group. More specifically, reality is viewed as constituted in the minds of individuals in interaction with other people and societal beliefs (Freedman & Coombs, 1996). As part of this postmodern view, narrative theorists believe many realities coexist. For the majority Black and Hispanic female prison population, the oppressive societal structures inherent in racism, classism, and sexism often work in tandem with other societal forces to further impinge on their functioning and devalue their status. These women have been given the message that they are the problem, and their dominant narrative is often one of failure. These lenses
limit clients’ views of themselves and others and prevent them from taking action. Postmodern approaches such as narrative therapy attempt to neutralize the forces of social and institutional power in such messages by helping clients to see more realities that offer alternatives for change.

Social Realities and Language

Another fundamental premise of narrative theory is that language is essential for understanding everyday reality. Just as the storying of experience is dependent on language, so too is the meaning we ascribe to our lives and relationships. Freedman and Coombs (1996, p. 29) argue that language makes our conversations with the people we serve. It also provides opportunities for negotiating new meanings for problematic beliefs, feelings, and behaviors—meanings that can give legitimacy to alternative views of reality. Carpenter (1996) reminds us that it is the client’s verbalizations and thinking about the problem, interacting with societal forces, that constitutes the reality of the problem. Therefore, for narrative therapists, language is an instrument of power. For incarcerated women, their marginalized existence often silences their voices or renders them less persuasive than other voices. Added to this problem is the fact that traditional intervention approaches applied within correctional settings often perpetuate the power relations that silence these women’s voices. For them, the use of language, whether to describe experiences or to articulate a plan for change, therefore becomes a source for enhancing self-esteem and of overall empowerment.

Realities Are Organized and Maintained Through Stories

White and Epston (1990) maintain that to make sense of our lives and to express ourselves, we story our experiences. The success of the storying of experience provides persons with a sense of continuity and meaning in their lives. Narrative therapy is about the retelling and reliving of these stories (Zimmerman & Dickerson, 1994). These authors maintain that as people tell their stories in therapy, they often notice that they have already experienced participating in an alternative story. Incarcerated women, with their weighted experiences of being discounted and pathologized, will benefit from the opportunity to tell their stories, many of which were untold and/or unheard. This approach not only allows the women to tell their stories but also enables a broader understanding of cultural and contextual factors implicated in them. McQuade and Ehrenreich (1998) argue that as women tell their stories, they narrate how they have survived and created arenas for choice. Strengths, resilience, and coping mechanisms are identified as women’s attempts to
transcend the loss of freedom, and the emotional and physical brutality of prison is recounted.

**There are No Essential Truths**

Modernism privileges what it considers to be a steadily growing body of objective knowledge derived from scientific experimentation and anecdotal studies. Narrative therapy and other postmodern approaches, on the other hand, operate from the premise that we cannot objectively know reality; all we can do is interpret it (Freedman & Coombs, 1996, p. 33). In a setting where interactions are often governed by stereotypical views of the inmate population, clients are viewed as important partners in the change process as their views and explanations are critical to successful intervention.

**The Process of Change**

The goal of narrative therapy is the generation of alternative stories that incorporate previously neglected aspects of lived experience. As such, clients are assisted in challenging those stories that limit the possibilities for change. They are helped to understand and then broaden and change the stories around which they have organized their lives. White and Epston (1990) identified two important stages in the narrative approach to treatment: a deconstruction and reconstruction phase. In the deconstruction phase, the problem-saturated stories that incarcerated women tell themselves are gradually deconstructed through questions that challenge the client’s narrow view of reality and draw out other aspects of the client’s life that have been ignored. However, Kelly (1996) cautions against deconstructing clients’ stories too quickly as they may need to have their stories heard, acknowledged, and understood before they are ready to move on.

Through summarizing and questioning, the clinician gradually helps the client deconstruct the dominant story in a search for other meanings and interpretations. This does not mean that the story is disputed; rather, the meaning is analyzed for other truths that are equally valid but may have been subjugated. In this process, the thoughts, beliefs, and social interactions around events are assessed for their influence on the individual (Kelly, 1996). Because narrative therapists see clients in context, they also listen for ways in which gender, culture, and social and economic context shape the clients’ worldviews and experiences. As White and Epston (1990) point out, this possibility is an important one as the sociopolitical contexts of clients’ lives have been long overlooked in the therapy literature.
In the reconstruction phase, clients are helped to reconstruct their views of reality by broadening their life stories. As alternative stories become available, previously neglected aspects of lived experience that have gone unstoried can be expressed. This is done by careful listening for “unique outcomes” as clients tell their stories (White & Epston, 1990). Clients are encouraged to recall events that contradict the problem’s effect on their lives and relationships. Questions are used to help the clinician analyze for alternative meanings and build on potential strengths, capabilities, and goal-attainment skills.

Narrative Approaches Within a Correctional Setting

The correctional setting poses some unique challenges for the implementation of narrative strategies. Among these challenges is the fact that these settings, by nature, are geared toward problem or deficit models of intervention. Correctional institutions place their emphasis on assessment techniques that largely rely on behavior profiles. These methods are more helpful in organizational planning and institutional management than in designing appropriate treatment plans for clients (Ivanhoff, Blythe, & Tripodi, 1994). In addition, practitioners usually have large caseloads and are expected to complete enormous amounts of paperwork geared at protecting their agencies from a litigious inmate population. In her discussion of challenges to the implementation of strengths-based intervention approaches, Van Wormer (2001) notes that third-party schemes mandate a diagnosis based on relatively serious disturbances in a person’s functioning (e.g., organic depression or suicide attempts) and short-term therapy to correct the presenting problem. She cites Saleebey’s (2001) argument that “the legal and political mandates of many agencies, the elements of social control embodied in both the institution and ethos of the agency, may strike a further blow to the possibility of partnership and collaboration between client and helper” (p. 33).

Despite this uneasy fit, the clinician, with a practice mandate to maximize the dignity and worth of the client, must find the means to do so within his or her practice role. Given the time or workload constraints in a jail or prison setting, efforts should be made to ensure that intervention begins as soon as possible after the client’s incarceration. Soon after the client begins to demonstrate stability and growth, it may be necessary to introduce group therapy. Group treatment could be quite effective with clients with substance abuse, mental illness, or histories of sexual or physical trauma. It helps victims share their experiences, provides an atmosphere of support, reduces the social stigma, and may further improve self-esteem.
Gaining a sense of personal power is especially important for women with histories of physical and sexual trauma. A significant number of them internalize stories about themselves that reinforce feelings of powerlessness, hopelessness, and shame. These distorted perceptions and traumatic self-images increase their vulnerability to substance abuse, mental health disorders, and other factors that increase recidivism rates. For many of these women, the ordinary response to trauma is to silence it because it is too difficult to deal with. Drugs therefore become the tool for quelling memories and feelings, broken dreams, and the inability to live up to societal ideals. Narrative approaches are especially helpful with incarcerated women who often incorporate the problem with their identity.

As with substance abuse, depression and other forms of mental illnesses frequently infiltrate the lives of incarcerated women in contexts where there have been histories of emotional, physical, or sexual exploitation or other forms of oppression relative to racism, sexism, and homophobia. The way in which the abuse is interpreted can also have a profound effect on the story that women tell about themselves. Durrant (1987) points out that people who have experienced sexual abuse are at risk for developing negative stories about themselves and that these stories prevent them from noticing examples of their competence and accomplishments.

Cultural expectations also influence the story that a woman who has experienced abuse develops about herself. For example, women in our culture are often influenced by established ideas of femininity and masculinity. As a result, they often privilege the voices of others over their own. Others confuse intimacy, sex, and violence. (Westcott & Dobbins, 1997).

A narrative approach allows the practitioner to address the patterns of interaction and the patriarchal culture that creates vulnerability to depression.

Externalizing the problem is a key approach in helping clients separate themselves from their problem. In this approach, the problem is decentered outside the person and so viewed as an internal impingement that needs to be changed. Through the use of metaphors and reflective questions, the clinician listens to the client’s definition of the problem and encourages him or her to objectify and at times to personify the problem. For example, the client would give the problem a name such as anger rather than just talking about how he or she gets angry (Abels & Abels, 2001). Giving the problem a name apart from oneself frees the client from seeing the problem as something inside the self.

Externalizing conversations, as described by White (1995), may also serve the important function of reducing feelings of shame and self-doubt and allow for important insights into the root causes of certain maladaptive
behaviors. Shame can often come from a disempowered lifestyle into which one is locked for many years—a lifestyle of substance abuse, incarceration, and loss. Feelings of shame can also come from a self-perceived failure to prevent the physical, emotional, and sexual abuse. Given the context of a jail setting where the usual strategies used to soothe emotions and cope with shame are not readily available, the social worker is especially responsible for establishing an inmate’s safety, avoiding further feelings of helplessness, and enhancing empowerment.

The process of decentering the person from the problem-dominated story is done by the use of language that originates the problem outside of the person. The actual description externalized is selected from the language that an individual uses to describe his or her experience. As a result, one can externalize the problem, the effects of the problem or cultural expectations, and practices that support the problem-dominated story. For example, an individual’s depression might be spoken of in an externalizing way. Questions that may facilitate the process include the following: What effects have depression had on you? How has it made you think of yourself as a person? What kinds of thoughts has it placed in your head? What direction did depression want you to take in your life? If it had its way, where would you be now? Questions should also be asked about the characteristic pressures that incarcerated women face and how these pressures might increase vulnerability to depression. By unmasking the sociocultural and sociopolitical context of depression, it is hoped that the problem will no longer be seen as a reflection of one’s identity but something that is supported and maintained by cultural and political discourses.

White and Epston (1990) refer to this process of externalizing the problem and internalizing positive qualities about oneself as reauthoring. The reauthoring process is facilitated by questions that externalize the problem-dominated story and the internalization of positive developments. This process is effective in that it can assist incarcerated women with problem-dominated stories to appreciate unique outcomes as examples of courage, determination, and strength in the face of continued oppression. It is a process of co-constructing more preferred stories about their lives.

**Developing More Validating Stories**

Abuse-dominated stories rob individuals of the experience of personal agency, competence, and compassion for themselves. White and Epston (1990) discuss the importance of joining with people as individuals before talking to them about their problems. The intent is to discover those aspects of a client’s life that are not dominated by abuse and its effects. Among the
discourses that usually characterize the life of the incarcerated female are narratives about being an “addict,” “depressed,” “dysfunctional,” and “multi-problematic.” A female inmate might also represent herself as an uncaring, irresponsible, and unfit mother to her children. This kind of sociocultural discourse creates a sense of inadequacy and, coupled with other problems, may lead to feelings of unworthiness, incompetence, and lack of control. Feelings of inadequacy can then lead inmates to doubt their parenting skills and question their abilities to ignore denigrating voices. For example, inmates might blame themselves for their histories of abuse. In such cases, part of their dominant stories might also include the belief that they could never be anything but addicts.

Examples of questions that may encourage more validating stories might include the following: Who recruited you into such an identity, or who assisted in the composition of the story? What have been the effects of this identity in terms of the actions that you can or cannot accept as your own? To what extent does this identity hold you back from certain thoughts, desires, values, and actions? What intentions does this identity have for your life? Do you have other intentions for the paths your life could take? Do your own intentions sometimes get clouded or overshadowed by the intentions that follow from this identity? (Freedman & Coombs, 1996; White, 1995; White & Epston, 1990). According to Sanders (1997), the intention in such conversations is to bring forth an externalization of the problem and open entry points to alternative stories or yet unconsidered ways of understanding and coping. For example, in discussions to clarify the many realities of his or her story, the client might be asked to consider how the events would be viewed differently if he or she were not involved.

**Re-Remembering Lost Identities**

After the clients’ problems have been externalized and the problem stories explored, clients can be invited to explore aspects of their lives that do not fit the problem story. Madigan (1997) suggests that persons entering into these re-remembering conversations are offered opportunities for alternative and reclaimed remembrances of who they are, who they have been, who they prefer to be, and who they might be in a possible future. Inmates might be invited to think about those times when they resisted being taken advantage of or when they recognized their accomplishments (Smith, 1997). This kind of conversation promotes a language of personal agency and empowerment rather than one of dependence and powerlessness. This may include questions such as, what have you done in the past that has helped you to have more influence over the problem? This can help women locate experiences that
contradict the problem-saturated story and invite them to begin to access their own self-knowledge (Westcott & Dobbins, 1997). When women’s voices are privileged and the problem is located within a sociocultural context, they can also separate the dominant cultural ideas that support their oppression and begin to re-remember their own special abilities and knowledge.

Using a reauthoring approach might begin by inviting such clients to talk about things they enjoy doing that have no direct connection to the presenting problem and by joining with them as unique persons (Freedman & Coombs, 1996; Smith, 1997; White, 1995; White & Epston, 1990). Such an invitation is important in reducing the sense of blame and shame that is so often a part of the story. Clients might also be invited to think about those times when they were able to step out of the problem identity and to speak out and stand up to the negative voices that attempted to confuse them. For example, many women are reluctant to leave an abusive relationship for socioeconomic reasons but would do so because of concerns for their children. In such cases, these women should be encouraged to give themselves credit for ending an abusive relationship and ensuring the protection of their children.

As a next step in the therapeutic process, Smith (1997) suggests that clinicians using this approach should invite clients to talk about which life direction they prefer. If clients indicate that they prefer the new alternative stories of themselves, they can be helped to find ways of making these stories endure in the face of temptations to return to the old stories. Smith (1997) offers a number of creative means that clinicians can use to help the preferred stories grow and endure. They include celebratory certificates, parties, videotape sharing, and letter writing. Clients can also be invited to wonder who might encourage and support their alternative stories and help them to endure. Finally, to ensure that clients are heading in a direction that they prefer, rather than trying to please the clinician, they can also be asked what the next preferred step might be (Smith, 1997).

**Conclusion**

In a correctional setting where the primary clinical mandate is to prevent suicides, cases with less destructive pathologizing discourses are seldom accorded much urgency. The large numbers of women with comorbidities of substance abuse, sexual and physical abuse, and mental illnesses often overtax a system that is both underfunded and understaffed. It then becomes incumbent on the social worker to empower these clients to become their own biographers. Change begins with their story telling. These stories are often replete with themes of oppression that are deeply rooted in the struc-
tures of a patriarchal society, racism, and poverty. Against society’s condemnation of them as criminals and unfit mothers, these women can be helped to realize how oppression has affected their personal and lifestyle decisions. Breaking the cycle of oppression involves the development of new and empowering self-narratives to replace those distorted thoughts that contributed to previous maladaptive behaviors. Narrative therapy can become a powerful tool for ensuring that the voices of incarcerated women are heard and that their preferred ways of being are taken seriously. This approach provides clinicians with an alternative means of helping jailed women organize and understand difficult experiences. In particular, narrative therapy examines the sociocultural factors that might have contributed to their present situation and develops an understanding of the barriers to enjoying a life of freedom.

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